STATE OF MINNESOTA DISTRICT COURT 08:43:12

COUNTY OF RAMSEY SECOND JUDICIAL DISTRICT

- -

THE STATE OF MINNESOTA,
BY HUBERT H. HUMPHREY, III,
ITS ATTORNEY GENERAL,

AND

BLUE CROSS AND BLUE SHIELD
OF MINNESOTA,

PLAINTIFFS,

VS. FILE NO. C1-94-8565

PHILIP MORRIS INCORPORATED, R.J.
REYNOLDS TOBACCO COMPANY, BROWN &
WILLIAMSON TOBACCO CORPORATION,
B.A.T. INDUSTRIES P.L.C., LORILLARD
TOBACCO COMPANY, THE AMERICAN
TOBACCO COMPANY, LIGGETT GROUP, INC.,
THE COUNCIL FOR TOBACCO RESEARCH-U.S.A.,
INC., AND THE TOBACCO INSTITUTE, INC.,

DEFENDANTS.

- -

DEPOSITION OF
BARBARA J. BOWERS, M.D.
VOLUME II

July 25, 1997
8:44 a.m.

REPORTED BY: JENNIFER S. SATI
REGISTERED PROFESSIONAL REPORTER
CERTIFIED REALTIME REPORTER
RAY J. LERSCHEN & ASSOCIATES
620 PLYMOUTH BUILDING
MINNEAPOLIS, MINNESOTA 55402

DEPOSITION OF BARBARA J. BOWERS, M.D.,

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VOLUME II, taken at the Law Offices of Robins, Kaplan, Miller & Ciresi, 2800 LaSalle Plaza, 800 LaSalle Avenue, Minneapolis, Minnesota, on the 25th day of July, 1997, commencing at 8:44 a.m., before Jennifer S. Sati, Notary Public.

* * * *

A P P E A R A N C E S

On Behalf of the Plaintiffs:

Robins, Kaplan, Miller & Ciresi
2800 LaSalle Plaza
800 LaSalle Avenue
Minneapolis, Minnesota 55402

BY: Howard R. Orenstein

On Behalf of Lorillard Tobacco Company:

Shook, Hardy & Bacon
One Kansas City Place
1200 Main Street
Kansas City, Missouri 64105

BY: Donald J. Kemna

ALSO PRESENT:

GARY W. WILLIAMS, Senior Analyst
Shook, Hardy & Bacon

JOE FERRARO, Video Deposition Company

* * * *

I N D E X

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MR. ORENSTEIN	232

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FURTHER EXAMINATION BY:
MR. KEMNA 237

* * * * *

EXHIBIT INDEX

NUMBER	PAGE MARKED
(None)	

THE VIDEOGRAPHER: Good morning, we're on the video record. Today's date is July 25, 1997. The time is now 8:44 a.m. This is a continuation of testimony given by Dr. Bowers, and the beginning of tape number 3. 08:44:18 08:44:20 08:44:24 08:44:28 08:44:28

May we have introduction of counsel 08:44:30

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present today. 08:44:30

MR. KEMNA: Don Kemna, Shook, Hardy & 08:44:38

Bacon, Kansas City, representing Lorillard. Along 08:44:40

with me today is Gary Williams from our office. 08:44:42

MR. ORENSTEIN: Howard Orenstein from 08:44:44

Robins, Kaplan, Miller & Ciresi, representing the 08:44:50

State of Minnesota and Blue Cross/Blue Shield of 08:44:52

Minnesota. 08:44:52

CONTINUING EXAMINATION

BY MR. KEMNA:

Q. Doctor, do you consider yourself to have any 08:45:18

expertise in the field of medical economics? 08:45:22

A. No. 08:45:24

MR. ORENSTEIN: Objection. 08:45:26

BY MR. KEMNA:

Q. Your answer was "no"? 08:45:30

A. (Witness nods head.) No. 08:45:34

Q. Doctor, are you aware that there were certain 08:45:56

Medicaid recipients who were the subjects of some 08:46:02

amount of discovery, that is medical records had 08:46:08

been collected with respect to certain individuals 08:46:10

who had been part of the Medicaid program, and that 08:46:14

depositions were taken of those individuals? 08:46:18

A. I'm not aware of that, no. 08:46:22

Q. Okay. So no medical records of Medicaid recipients, 08:46:26

nor any depositions of Medicaid recipients were made 08:46:32

available to you to form any part of the basis of 08:46:36

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your testimony; is that correct? 08:46:36

A. Yes, that is correct. 08:46:38

Q. And by your answer to my initial question in this area, I take it that you were not ever offered the opportunity to review Medicaid recipient specific material such as medical records or transcripts of depositions; is that correct? 08:46:44 08:46:50 08:46:54 08:46:58 08:46:58

MR. ORENSTEIN: Objection; overbroad. 08:47:00

THE WITNESS: I have not reviewed any medical records pertaining to this process. 08:47:06 08:47:12

BY MR. KEMNA:

Q. And no one made an offer that you may have the opportunity to review that type of material; is that correct? 08:47:14 08:47:18

A. That is correct. 08:47:20

Q. Doctor, have you ever been involved as a party that is either as a plaintiff or a defendant in a 08:47:30 08:47:34

lawsuit? 08:47:34

A. We talked about the issue with the partner that we fired. We talked about that the last tape. Are you referring to that? 08:47:50 08:47:56 08:47:58

Q. Perhaps. 08:47:58

A. That type of situation? 08:47:58

Q. Yeah, exactly, where, in fact, you may have been named personally as a defendant or initiated a lawsuit personally as a plaintiff or as a member of the medical practice you're in either were named as a defendant as part of the practice or initiated a 08:48:02 08:48:10 08:48:14 08:48:20 08:48:24

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lawsuit as a member of the practice against some other party? 08:48:28 08:48:28

MR. ORENSTEIN: Maybe you could just clarify that that's what you mean by "party" as opposed to a witness. 08:48:30 08:48:32 08:48:34

MR. KEMNA: Yeah. 08:48:36

BY MR. KEMNA:

Q. This question relates purely to your participation as someone with an interest in the lawsuit. For instance, as a plaintiff filing the lawsuit or as someone defending as a defendant. 08:48:42 08:48:46 08:48:50 08:48:52

Not participation as an expert witness or not participation as a witness apart from being a party to the lawsuit. 08:48:54 08:49:00 08:49:02

A. Yes, so the Minneapolis Medical Specialists lawsuit with one of our partners would qualify as that situation. 08:49:08 08:49:12 08:49:12

Q. Correct. And what I intend to follow-up on is if there are any other matters other than the one that you mentioned? 08:49:18 08:49:20 08:49:22

A. Not any that I can remember. 08:49:24

Q. Okay. So that just to get final clarification on that, you have not been involved in any matter where you or your practice has been named as a defendant in a medical malpractice lawsuit; is that correct? 08:49:32 08:49:36 08:49:40 08:49:44

A. Not that I can remember. 08:49:46

Q. Doctor, you've indicated in your expert report that 08:51:32

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part of your testimony will relate to some costs that are associated with the treatment of lung cancer; is that correct? 08:51:38 08:51:42 08:51:44

A. That's correct. 08:51:44

Q. Have you attempted, over the course of your practice or in preparation for your participation in this case, to collect data within your office setting that would specify costs that are attributable to your treatment of Medicaid patients versus private-pay patients? 08:51:52 08:51:58 08:52:04 08:52:10 08:52:14 08:52:16

A. I have not, no. 08:52:18

Q. In your estimate of costs associated with the 08:52:24

treatment of lung cancer, do you have any basis to directly attribute those costs that you've estimated in your expert report to Medicaid recipients or Blue Cross and Blue Shield recipients as have been described as one party to this lawsuit? 08:52:28 08:52:40 08:52:46 08:52:52 08:52:56

MR. ORENSTEIN: Objection; ambiguous and compound question. 08:53:00 08:53:02

THE WITNESS: Can you make that question a little bit more clear? I'm not sure exactly what I'm answering. 08:53:14 08:53:18 08:53:18

BY MR. KEMNA:

Q. Okay. I'll break it up a bit. 08:53:20

A. Yes. 08:53:22

MR. KEMNA: Let's go off the record for just a second. 08:53:28 08:53:30

THE VIDEOGRAPHER: The time is now 8:53 08:53:32

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and we're temporarily going off the video record. 08:53:34

(Off the record.) 08:53:38

THE VIDEOGRAPHER: We're back on the video record. The time is now 8:55. 08:55:04 08:55:08

BY MR. KEMNA:

Q. Doctor, I'm going to hand you what has been previously marked as Deposition Exhibit 2503 entitled, "Plaintiffs Expert Report, Barbara J. Bowers," and ask you to refer to page 4 of your report. 08:55:26 08:55:30 08:55:34 08:55:42 08:55:42

MR. ORENSTEIN: Counsel, yesterday we had a little interchange about what you mean by report. I think what I mean by the report is probably the entire report, including her C.V. and other attachments. 08:55:58 08:56:00 08:56:02 08:56:02 08:56:04

You're referring to 2503, which is basically the medical substance of her report; is that what you mean? 08:56:06 08:56:10 08:56:10

MR. KEMNA: Yes, the text of her report. We have the C.V. marked as a separate exhibit. 08:56:14 08:56:16

MR. ORENSTEIN: So we have an understanding that when you refer to her report it may not include all of the matters that were submitted with the report? 08:56:18 08:56:20 08:56:22 08:56:24

MR. KEMNA: Yeah. There's really no intention on my part to be exclusive of any other materials you may have originally attached to the 08:56:26 08:56:30 08:56:32

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text of the document entitled Plaintiffs' Expert Report. 08:56:36 08:56:38

If that's a matter of some concern to you, you know, certainly you'll have the opportunity to make any clarification necessary. 08:56:42 08:56:44 08:56:46

MR. ORENSTEIN: I think you've clarified it. 08:56:48 08:56:50

BY MR. KEMNA:

Q. Doctor, if you'd refer to the last paragraph on page 4, you have some information regarding, you know, rough estimates of the annual cost for office visits, lab and chemo. 08:56:52 08:57:02 08:57:04 08:57:08

You indicate they can range from a few thousand to greater than 20,000 a year. You make reference to hospital or nursing home costs. 08:57:10 08:57:14 08:57:20

How did you come about estimating the costs associated with the treatment for lung cancer? 08:57:24 08:57:28 08:57:30

MR. ORENSTEIN: Objection; mischaracterizes her testimony. 08:57:34 08:57:34

THE WITNESS: Again, these are estimates based on what we see in our office, roughly, and information that we get through our patients in discussing their problems with them. 08:57:40 08:57:48 08:57:54 08:57:56

BY MR. KEMNA:

Q. Okay. Did you make any effort to actually go back and review the billing records regarding the treatment of patients in your office to confirm some 08:58:02 08:58:06 08:58:12

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estimate or range of cost figures associated with the treatment of lung cancer patients? 08:58:18 08:58:20

A. I did not review any billing records for these numbers. 08:58:26 08:58:26

Q. Okay. So that your figure of from a few thousand to greater than $20,000 a year relates to your present recollection of costs that have been associated with treating a variety of patients over time? 08:58:38 08:58:44 08:58:50 08:58:52

A. It's from a compilation of what you would expect for lung cancer patients as we see them from people who require a very minimal amount of care to those who require very extensive care. 08:58:58 08:59:04 08:59:08 08:59:12

Q. Do you mean to convey by giving this estimate in your report that the costs associated with the treatment of lung cancer in your office is representative of all other offices of oncologists who would be treating lung cancer patients? 08:59:22 08:59:30 08:59:30 08:59:36 08:59:38

A. I think that it would be very representative of other oncology offices in the State of Minnesota. 08:59:46 08:59:48

Q. Are you familiar with the billing practices of other offices that have oncology practices in the State of Minnesota, specifically relating to the treatment of lung cancer patients? 08:59:54 09:00:00 09:00:02 09:00:02

A. I have been a partner in another group, but in addition all physicians in Minnesota have criteria where we are told whether we fall out of a certain bell-shape curve of practice as far as charges. 09:00:14 09:00:22 09:00:28 09:00:36

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So there is a mechanism that we have professionally to make sure that we are in line with

the rest of the community.

Q. This report to you that indicates whether your office is rated appropriately regarding the costs of assessing treatment and the costs of treatment of lung cancer patients, does that relate to cumulative costs regarding specific diagnoses or does it relate to just individual matter costs?

A. I'm not sure what you mean by individual matter costs, but they do not break it down by disease, no, if that's what you are referring to.

Q. Okay. What organization reports to you data on whether your office is within the bounds of what is considered as reasonable costs to be assessed by an oncologist's office?

A. The various insurance companies will let us know if we are outside of the norm for the state.

Q. Do all insurance companies that you interact with report these kind of figures to you?

A. I do not know if all of the insurance companies do.

Q. Does Blue Cross/Blue Shield report to you whether you are within the boundaries of reasonable costs or outside the boundaries?

A. I'm not sure exactly which insurance companies give us that data. You would have to talk with the people in our business office.

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Q. There are quite a number of variables involved in what is included within the treatment of lung cancer; isn't that true, Doctor? 09:02:58 09:03:02 09:03:04

MR. ORENSTEIN: Objection; ambiguous, overbroad. 09:03:08 09:03:10

THE WITNESS: I'm not -- you would have to delineate what you mean by that. 09:03:12 09:03:14

BY MR. KEMNA:

Q. The treatment of a lung cancer patient is not standard as to some specific set of procedures or drug therapy or radiation therapy or any other mode of therapy that's available to you, you tailor the treatment to the individual patient; isn't that correct? 09:03:20 09:03:24 09:03:32 09:03:34 09:03:38 09:03:38

A. You need to tailor the treatment to the individual patient. There is a broad spectrum of treatment possibilities, however, that are used in a given disease, lung cancer being one of those diseases. 09:03:42 09:03:50 09:03:54 09:03:56

Q. The low end of the treatment costs associated with lung cancer is what? 09:04:06 09:04:10

A. Again, I believe I state in the report on a yearly basis, but a lung cancer patient who is coming in for intermittent follow-ups, say, after primary resection of a lung nodule and needs to be followed up for symptoms that may be associated with 09:04:18 09:04:24 09:04:30 09:04:36 09:04:40

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metastatic disease with the regular follow-up would be the low end, where they are not receiving chemotherapy or radiation therapy on a regular basis. 09:04:46 09:04:48 09:04:54 09:04:54

Q. Okay. There's quite a difference in survival times of lung cancer patients, aren't there, Doctor? 09:05:00 09:05:02

A. That's true of all patients, yes. 09:05:04

Q. Particularly, though, with lung cancer patients; isn't that true? 09:05:06 09:05:08

MR. ORENSTEIN: Objection. 09:05:08

THE WITNESS: I do not know what you mean by particularly. There are other cancers and other disease entities where there's quite a bit of variability, too. So I don't know that we can single out lung cancer. 09:05:12 09:05:14 09:05:18 09:05:20 09:05:22

BY MR. KEMNA:

Q. The survival statistics regarding lung cancer are not particularly good compared to a number of different disease categories, wouldn't you agree with that? 09:05:26 09:05:30 09:05:32 09:05:32

MR. ORENSTEIN: Objection; ambiguous. 09:05:34

THE WITNESS: I would have to know which diseases you were talking about. 09:05:36 09:05:38

BY MR. KEMNA:

Q. Let's say lung cancer versus nonmalignant processes of the lung. 09:05:50 09:05:50

MR. ORENSTEIN: Counsel, could I just ask 09:05:52

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for a clarification? When you say the statistics are not particularly good, do you mean the data isn't good or the survival rates are not good? 09:05:56 09:05:58 09:06:06

MR. KEMNA: If she has a problem interpreting the question, she can ask for clarification. 09:06:08 09:06:10 09:06:14

BY MR. KEMNA:

Q. If the question doesn't make sense, you know, as we did the other day, you can let me know. 09:06:16 09:06:18

A. Okay. 09:06:20

MR. ORENSTEIN: I have a continuing objection based on ambiguity and vagueness. 09:06:22 09:06:24

THE WITNESS: I would have to have it clarified and the question be more specific to what we are talking about with various diseases. 09:06:26 09:06:30 09:06:32

BY MR. KEMNA:

Q. What's the overall survival, on a percentage basis, for five-year survival of lung cancer generally? 09:06:40 09:06:44

A. Generally about 20 percent or less, but it depends on stage of cancer. Obviously, stage 1 having the longer potential survival. The higher stages fall off fairly dramatically. 09:06:52 09:06:56 09:07:02 09:07:04

Q. And the survival time expected for an individual 09:07:12

patient varies based upon what their individual diagnosis is; isn't that correct? 09:07:16 09:07:20

A. That is correct. 09:07:20

Q. And for a patient who has small cell carcinoma of 09:07:26

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the lung, the expected survival time is relatively short compared to other cell types of lung cancer, would that be correct? 09:07:32 09:07:36 09:07:36

A. With small cell, the survival time untreated is very short. However, if they respond to treatment, they may have a very prolonged survival. 09:07:40 09:07:46 09:07:48

Q. In your office, Doctor, do you assign the billing codes for particular diagnoses for reimbursement purposes through third-party payers? 09:07:58 09:08:06 09:08:08

A. Does our office assign codes? We need to assign diagnostic codes so the insurance can pay. Do I actually put the code on the form? No. 09:08:12 09:08:20 09:08:22

Q. Okay. What's the source of the code information that's used? 09:08:26 09:08:28

A. Dictations and written diagnoses. 09:08:34

Q. Okay. What source -- what reference source would you go to to determine what the appropriate code is for a particular diagnostic category? 09:08:46 09:08:50 09:08:52

A. There's a book of CPT codes by diagnoses that are available for the billing office to assign the appropriate code. 09:09:02 09:09:06 09:09:06

Q. What's the origin of CPT codes? 09:09:12

MR. ORENSTEIN: Objection; lack of foundation. 09:09:14 09:09:14

THE WITNESS: I would not have a clue. I just know they are available. 09:09:16 09:09:16

BY MR. KEMNA:

Q. Okay. You're not sure from what disease 09:09:22

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classification system that this coding system may have been derived from; is that correct? 09:09:28 09:09:30

A. I have no information how CPT codes came about and what their origin was, no. 09:09:34 09:09:36

Q. Okay. What is CPT? 09:09:40

A. I don't even know what the letters stand for. 09:09:44

Q. Do you know what the code is for lung cancer? 09:09:50

A. No, I do not. 09:09:52

Q. When you make a diagnosis of lung cancer in your office or a notation of the diagnosis of lung cancer, do you know what code is assigned to that? 09:10:00 09:10:04 09:10:08

A. We have people in the office that that is their area of expertise, so I do not look at the code nor do I assign the code. 09:10:12 09:10:20 09:10:20

Q. Are they physicians? 09:10:22

A. They are coders. 09:10:24

Q. Okay. What kind of background do these coders have? 09:10:28 09:10:28

MR. ORENSTEIN: Objection; lack of foundation. 09:10:30 09:10:30

THE WITNESS: You would have to ask the administrative people that hire them. 09:10:32 09:10:34

BY MR. KEMNA:

Q. Okay. You mentioned that you were previously with a different office practice, perhaps it was a partnership. What was the name of that practice group? 09:10:40 09:10:44 09:10:50 09:10:50

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A. Minneapolis Medical Specialists. 09:10:52
Q. Okay. What is the group that you're currently affiliated with? 09:10:58
A. Minnesota Oncology Hematology. 09:11:02
Q. How long have you been affiliated with Minnesota Hematology Oncology? 09:11:10
A. Approximately five years. 09:11:12
Q. And before that, the organization that you were affiliated with, how long were you with them? 09:11:18
A. Five to seven years. I can't remember exactly. 09:11:22
Q. Were you a solo practitioner prior to becoming affiliated in the -- 09:11:26
A. Yes. 09:11:36
Q. -- any group practice? 09:11:38
A. Yes. 09:11:38
Q. How long were you in solo practice? 09:11:40

A. For about five years. 09:11:42
Q. When you were in solo practice, did you get directly involved with the billing for your treatment of lung cancer patients? 09:11:44
A. No, I did not. 09:11:50
Q. Who handled the assignment of billing codes to the documentation that you made regarding your patients and diagnoses? 09:11:56
MR. ORENSTEIN: When she was in private practice, solo practice? 09:12:00
BY MR. KEMNA: 09:12:00
Q. Yes, while you were in solo practice. 09:12:04
09:12:08
09:12:10
09:12:12
09:12:12
09:12:16

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A. A company that I hired to manage the office. 09:12:20
Q. Okay. What procedure was used in getting the 09:12:26
information to this outside organization that 09:12:30
performed the billing for you? 09:12:32
A. When patients come in, you write their diagnoses out 09:12:36
in longhand on a billing form. That form is used to 09:12:44
do the coding. 09:12:46
Q. Did you ever have the opportunity to go back and 09:12:52
check the accuracy of the billing office's 09:12:58
assignment of diagnostic codes to your handwritten 09:13:02
diagnoses? 09:13:04
A. I have not seen any need to do that, but, no, I have 09:13:10
not. 09:13:10

Q. Are you aware of studies that have been conducted 09:13:16
that reflect inaccuracies between what a provider's 09:13:20
designation of diagnosis is and the assignment of 09:13:26
diagnostic codes to that information by 09:13:30
nonphysicians? 09:13:32
MR. ORENSTEIN: Objection; assumes facts 09:13:34
not in evidence. 09:13:34
THE WITNESS: I obviously have no 09:13:38
expertise on these studies, nor have I reviewed any 09:13:44
of those studies. 09:13:46
BY MR. KEMNA:
Q. Doctor, are you familiar with the World Health 09:13:54
Organization?
A. I know of the World Health Organization, yes. 09:13:58

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15	Q.	Do you know whether they have a coding system within	09:14:02
16		the World Health Organization for a standardized	09:14:06
17		approach to diagnoses in medicine?	09:14:10
18	A.	No, I do not know if they have a coding system.	09:14:12
19	Q.	Have you ever heard of the international	09:14:16
20		classification of diseases?	09:14:18
21	A.	Yes.	09:14:20
22	Q.	Do you know whether that is a WHO standard	09:14:26
23		classification of diseases?	09:14:30
24	A.	No, I do not know.	09:14:30
25	Q.	Are you familiar with how specific the billing	09:14:46

1		offices -- and I'll just categorize within this any	09:14:50
2		billing office that's been affiliated with a	09:14:52
3		practice of yours through the years. Are you	09:14:56
4		familiar with the level of specificity that these	09:15:06
5		codes have toward diagnoses of subtypes of lung	09:15:10
6		cancer?	09:15:10
7	A.	I do not know how specific they are. I know they	09:15:14
8		want us to write the subtype on the report, that	09:15:20
9		lung cancer is not adequate for them. They want us	09:15:24
10		to write the pathologic diagnoses.	09:15:26
11	Q.	Okay. So that, for instance, if you were diagnosing	09:15:30
12		a patient with small cell carcinoma of the lung, the	09:15:38
13		billing office would find a code that was specific	09:15:44
14		to small cell carcinoma of the lung in order to seek	09:15:46
15		reimbursement from whatever organization is involved	09:15:52
16		in reimbursing you for the treatment cost; is that	09:15:54
17		correct?	

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MR. ORENSTEIN: Objection; lack of foundation. 09:15:56

THE WITNESS: I do not know what they do once they get the information. I know what information they want of me. And that is to put the full diagnosis down as it comes across from the path report. 09:15:58 09:16:02 09:16:04 09:16:10 09:16:10

BY MR. KEMNA:

Q. Doctor, are you familiar with the operation of the Minnesota Medicaid system in terms of what its requirements are for billing? 09:16:16 09:16:22 09:16:24

A. No, I'm not. 09:16:24

Q. Doctor, have you ever discussed with plaintiffs' counsel or anyone associated with this litigation the statistical modeling approach that plaintiffs have in mind for establishing the costs attributable to cigarette smoking in Minnesota Medicaid? 09:16:50 09:16:54 09:17:04 09:17:08 09:17:10

A. No, I -- 09:17:12

MR. ORENSTEIN: That's fine. I'm going to instruct her not to answer questions regarding our discussions. 09:17:16 09:17:18 09:17:20

THE WITNESS: Okay. 09:17:22

BY MR. KEMNA:

Q. Are you familiar with the statistical modeling that will purportedly be used in this case in an attempt to demonstrate costs attributable to smoking of the diseases that are alleged to be associated with 09:17:26 09:17:30 09:17:36 09:17:40

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smoking? 09:17:42

A. I am not familiar with the model that they use, no. 09:17:46

Q. Have you ever heard of the NMES survey? 09:17:54

A. No. 09:17:56

Q. Have you ever looked for any errors that may have been made in coding the particular diagnoses that 09:18:14 09:18:20

are made in your office for billing purposes? 09:18:24

A. No. 09:18:26

Q. Do you have any level of expertise with respect to the proportion of Medicaid costs in Minnesota that might be attributable to cigarette smoking? 09:18:40 09:18:48 09:18:50

A. Can you ask that question again? 09:18:56

MR. KEMNA: Why don't you read that back. 09:19:00

(The requested portion read back.) 09:19:10

THE WITNESS: No. 09:19:14

BY MR. KEMNA:

Q. Do you have any expertise regarding the costs reimbursed by Blue Cross and Blue Shield that might be said to be attributable to cigarette smoking? 09:19:32 09:19:40 09:19:44

A. No. 09:19:44

Q. Doctor, do you ever fill out death certificate forms? 09:20:22 09:20:24

A. Yes. 09:20:24

Q. And I take it that based on the scope of your practice, you probably fill out death certificates from time to time regarding lung cancer patients; is that correct? 09:20:32 09:20:36 09:20:40

A. That is correct. 09:20:40

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Q. What level of specificity do you put down on the death certificate regarding cause of death in patients who die of lung cancer? 09:20:50 09:20:56 09:21:00

A. I put down the disease that they die from and any additional diseases that we are aware of and complications. 09:21:08 09:21:16 09:21:16

Q. Okay. For example, if a patient dies of small cell carcinoma of the lung, do you put down as cause of death lung cancer, or do you put down small cell carcinoma of the lung? 09:21:22 09:21:26 09:21:30 09:21:30

A. I put down small cell carcinoma of the lung. 09:21:34

Q. Okay. In patients that you become involved in the treatment process, are you typically the individual who would fill out a death certificate for a lung cancer patient or would someone else within the treatment team be responsible for that? 09:21:50 09:21:58 09:22:06 09:22:08 09:22:10

A. In our office, the physician taking care of the patient fills out the death certificate. We will get the death certificate if we are taking care of the patient at the time of death. And the doctor that is the attending for that patient fills out the death certificate. 09:22:16 09:22:24 09:22:26 09:22:32 09:22:34 09:22:36

Q. Okay. So that, for instance, if you are called in to consult on a case, you're in the course of follow-up on the diagnosis of lung cancer, but the primary care physician is still within the team involved with the patient, you would fill out the 09:22:42 09:22:50 09:22:56 09:23:00 09:23:04

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death certificate rather than the primary care 09:23:08

physician? 09:23:08
A. If we were taking care of the patient at the time of 09:23:12
death. 09:23:12
Q. Have you ever reviewed data compiled on the accuracy 09:23:24
of information included on death certificates as 09:23:30
compared to actual autopsy information that relate 09:23:38
to the diagnosis of the patient? 09:23:42
A. I have not reviewed such data, no. 09:23:44
Q. Okay. Would it surprise you to find that there is a 09:24:04
significant disagreement between information that is 09:24:08
provided on death certificates versus information 09:24:12
attained through the autopsy regarding a population 09:24:20
of patients? 09:24:20
MR. ORENSTEIN: Objection; assumes facts 09:24:24
not in evidence, calls for speculation, lack of 09:24:26
foundation. 09:24:26
THE WITNESS: I would not be able to 09:24:28
speculate on that at all. 09:24:30
BY MR. KEMNA:
Q. Okay. You've never heard or read about any problem 09:24:38
encountered in medicine with respect to the 09:24:40
inaccuracy of death certificate information? 09:24:44
A. I have no basis to -- I have no idea what studies 09:24:54
you are talking about and have no way of giving an 09:24:58
opinion on the studies that I have not looked at. 09:25:02

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Q. You indicated in our previous day of deposition that -- and this may be a paraphrase -- but the vast majority of the patients that are referred to you already have been diagnosed with their condition, for instance, lung cancer; is that correct? 09:25:16 09:25:22 09:25:24 09:25:28 09:25:30

A. That is correct. 09:25:30

Q. So that whatever diagnostic information has already been provided through medical records or whatever other source that you have for the standing diagnosis on the patient is something that would just, for the most part, be passed through in your office to whatever might occur on a death certificate; is that accurate? 09:25:36 09:25:40 09:25:44 09:25:46 09:25:52 09:25:54 09:25:56

MR. ORENSTEIN: Objection. 09:25:56

THE WITNESS: I do not think that that scenario is accurate. The patient will come with a diagnosis of cancer. They may or may not have had tests that would be used to stage them. The path report is evaluated. 09:26:00 09:26:04 09:26:12 09:26:22 09:26:24

And if there's any question, that path report is sent out for another opinion or we ask the past slides to be sent to another institution for another opinion. 09:26:28 09:26:32 09:26:36 09:26:36

So I think that that's the information that we use in making the diagnosis that we use to 09:26:38 09:26:48

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treat the patient, as well as the diagnosis that we use to put on the death certificate. 09:26:50 09:26:52

Q. Do you make an attempt through the course of your treatment of a patient to evaluate the question of whether you are indeed dealing with a primary cancer of the lung or a metastases to the lung from some occult site? 09:27:00 09:27:08 09:27:10 09:27:14 09:27:18

A. That's part of the evaluation of the patient, yes. 09:27:22

Q. What procedures do you utilize in order to make that determination? 09:27:26 09:27:28

A. The path report, various x-rays, history, physical exam. 09:27:38 09:27:38

Q. Do you do procedures to examine the entire body to determine whether cancer occurs at nonlung sites that may likely be a primary site? 09:27:52 09:27:58 09:28:00

A. If the pathology would indicate that, or one of the x-rays would indicate that this is -- that there's any question that this is not a primary pulmonary process, we look very extensively to assure that we do not have another source, because it makes a difference in the medications, treatment, follow-up that we recommend for the patient. 09:28:06 09:28:12 09:28:16 09:28:22 09:28:26 09:28:30 09:28:32

Q. If someone presents with a cancer in the lung that is reflected by a chest x-ray and a finding by pathology that, indeed, it is cancer, and the 09:28:50 09:29:02 09:29:08

treaters who have made the diagnosis have not raised any question regarding whether this is a primary or a metastases, would you take it upon yourself to 09:29:14 09:29:18 09:29:24

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conduct your own inquiry as to whether this is a primary or a metastases? 09:29:26 09:29:28

A. If I felt that was indicated, absolutely. 09:29:32

Q. Okay. What types of scenarios would present that would spur you on to investigate in that type of a patient? 09:29:40 09:29:44 09:29:44

A. There are probably many scenarios. I could give you an example. 09:29:54 09:29:54

Q. Okay. 09:29:56

A. I certainly would not claim to be covering all scenarios. 09:29:58 09:30:00

Q. Okay. 09:30:00

A. A female patient comes in with a solitary lung lesion on chest x-ray. Bronchoscopy or needle biopsy of that shows this to be an adenocarcinoma. 09:30:08 09:30:18 09:30:20

Definitely you would want to rule out that there was an adenocarcinoma of the breast. You would want to make sure that the pelvic exam was normal, stools for guaiac were normal, and there were no other G.I. symptoms, and that CT scans, lung scans, et cetera, were normal. 09:30:24 09:30:26 09:30:30 09:30:34 09:30:42 09:30:56

In addition, you would ask pathology to 09:30:58

make sure that they have done markers looking for estrogen and progesterone receptors to see if breast cancer would be a possibility. 09:31:00 09:31:08 09:31:10

Q. Doctor, are you satisfied with every patient that you see that you know that their cancer is 09:31:26 09:31:38

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specifically a primary or a metastases to the lung? 09:31:42
A. No. 09:31:42
Q. What proportion of your patients would you say that 09:31:48
there is reason for questioning whether the cancer 09:31:52
is a primary or a met to the lung? 09:31:58
MR. ORENSTEIN: Objection; calls for 09:32:00
speculation, lack of foundation. 09:32:02
THE WITNESS: I have never looked at the 09:32:02
specific percentages. If you ask if that exists, 09:32:08
that does, and we document it as such. 09:32:10
BY MR. KEMNA:
Q. Would you say it's on the level of being not 09:32:20
uncommon? 09:32:20
MR. ORENSTEIN: Objection. 09:32:22
THE WITNESS: I just cannot guess at 09:32:26
percentages or a vagary such as uncommon, not 09:32:30
uncommon. All I can say is that it is seen and it 09:32:34
is documented as such. 09:32:34
BY MR. KEMNA:
Q. Is it such a rarity that you've only seen it occur 09:32:46

one time in your practice? 09:32:46
A. No. 09:32:48
Q. Would you say that in the course of a year that you 09:32:58
would see at least one case of questionable 09:33:02
diagnosis regarding primary or metastases in the 09:33:08
lung? 09:33:08
MR. ORENSTEIN: Objection; calls for 09:33:10
speculation. 09:33:10

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THE WITNESS: I would have to review our -- what percentage of cancers of unknown primary we have in our office. I do not know how many patients we see, what percentage of the patients we see that would be. 09:33:16 09:33:22 09:33:24 09:33:28 09:33:30

BY MR. KEMNA:

Q. But it is what an oncologist would expect to see in the ordinary course of their practice; isn't that correct? 09:33:38 09:33:40 09:33:40

A. Yes. 09:33:42

MR. ORENSTEIN: Objection. 09:33:42

THE WITNESS: It is something that we see, yes. 09:33:44 09:33:44

BY MR. KEMNA:

Q. Doctor, would you agree that patients who are seen by you that are part of the Medicaid system for reimbursement of your treatment costs would 09:34:26 09:34:34 09:34:38

generally be among the lower socioeconomic strata in Minnesota? 09:34:52 09:34:52

A. I think by definition to qualify for the program you have to have -- be among the lower economic levels or you don't qualify for the program. 09:35:02 09:35:06 09:35:10

Q. Are you aware that lower socioeconomic status has been associated with the increased incidence of lung disease? 09:35:20 09:35:26 09:35:26

MR. ORENSTEIN: Objection; assumes facts not in evidence. 09:35:28 09:35:30

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THE WITNESS: You would have to look at a statistician or an epidemiological expert to give you that information. 09:35:32 09:35:36 09:35:38

BY MR. KEMNA:

Q. So at this point, you have no opinion on whether socioeconomic status may have been associated with an increased incidence of lung disease; is that correct? 09:35:42 09:35:46 09:35:52

A. That's right. 09:35:54

Q. From a medical practitioner's point of view, would you expect to see an increased incidence of lung disease in patients of lower socioeconomic status? 09:36:06 09:36:08 09:36:12

A. Not specifically. 09:36:16

Q. Would you expect to see an increased incidence of infectious disease in patients who are within the 09:36:36 09:36:42

socioeconomic status that would be included in the Medicaid program in Minnesota? 09:36:46 09:36:46

MR. ORENSTEIN: Objection; overbroad, calls for speculation. 09:36:50 09:36:52

THE WITNESS: I think you'd have to talk with the people dealing with infectious disease. 09:36:52 09:36:56

BY MR. KEMNA:

Q. Okay. So within your practice, Doctor, you have not really either anecdotally or systematically determined for yourself that there is a greater problem with infectious disease within people of lower socioeconomic status? 09:37:02 09:37:08 09:37:14 09:37:16 09:37:18

A. In my practice as an oncologist, our patients all 09:37:26

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tend to be -- have the potential of being immune compromised, and it doesn't matter how much money they make. 09:37:32 09:37:36 09:37:36

So we see infectious disease in all groups that we are currently treating, and it does not seem to have any correlation with their economic background. But we do not see a general population of patients. 09:37:40 09:37:46 09:37:50 09:37:54 09:37:54

Q. As you indicated the other day, you really have never differentiated between patients in your office based upon whether they were part of the Medicaid reimbursement program or whether they were part of 09:38:00 09:38:08 09:38:12 09:38:14

Blue Cross or Blue Shield or any other insurance program; is that correct? 09:38:18 09:38:20

MR. ORENSTEIN: For treatment purposes? 09:38:24

THE WITNESS: For treatment purposes, that is correct. 09:38:26 09:38:26

BY MR. KEMNA:

Q. As a practical matter, Doctor, are you restricted at all in the way that you treat your patients by the nature of the program that is overseeing the reimbursement of the treatment costs? 09:38:40 09:38:44 09:38:48 09:38:50

A. Can you clarify what you mean by that? 09:38:54

Q. Well, there's been a good deal of publicity regarding the effects of what is generally regarded as managed care over the freedom of physicians to practices they might ordinarily practice in the 09:38:58 09:39:02 09:39:10 09:39:14

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treatment of their patients. 09:39:16

Is there any ring of familiarity to that 09:39:18
concept with regard to the way you practice? 09:39:22

MR. ORENSTEIN: Counsel, you're -- I'm 09:39:26
trying to allow you some latitude in terms of your 09:39:28
questions for areas that might arguably pertain to 09:39:34
her expert report, but I'm going to object to this 09:39:36
question and others where I think it's just very far 09:39:38
field. 09:39:38

BY MR. KEMNA:

Q. That's fine. You can answer the question. 09:39:42
A. I'll go back to the -- my point that what I order 09:39:50
for the patient and the treatment I give the patient 09:39:54
does not depend, nor is it dictated, by the type of 09:40:00
insurance that they have. 09:40:00
Q. Are you aware, Doctor, of the degree to which the 09:40:20
Medicaid system reimburse the cost of your treatment 09:40:26
versus other programs for reimbursement that might 09:40:34
represent the private pay community? 09:40:36
A. The reimbursement for the Medicaid patient is at a 09:40:46
lower rate than many of the private pay. Exactly 09:40:54
how that breakdown -- or to the exact extent I 09:40:56
cannot say, and how it correlates with other 09:41:02
insurances I cannot tell you exactly how that 09:41:08
breakdown is. 09:41:08
Q. How did you come by making that determination 09:41:12
regarding reimbursement from the Medicaid system 09:41:16
versus reimbursement from other insurance payers or 09:41:20

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just private pay patients? 09:41:22
A. Again, the business office will tell us that there 09:41:32
are certain cutoffs or certain levels that the 09:41:40
various insurances are paying, but not specifically 09:41:42
by the insurance. 09:41:44
And we have not broken down on the basis 09:41:52
of a given insurance what the reimbursement is for 09:41:58

various services. We've not done that. 09:42:02
Q. Your business office in remarking to you about the 09:42:20
degree of reimbursement from the Medicaid program, 09:42:24
for instance, do they break it down for you as to 09:42:28
whether these patients were lung cancer patients or 09:42:32
whether they were some other type of patients? 09:42:34
A. No, they do not. 09:42:36
Q. So at this point, you don't really specifically know 09:42:46
whether the degree of reimbursement from the 09:42:50
Medicaid program, specifically with respect to lung 09:42:52
cancer patients, is any different from any other 09:42:56
program of reimbursement from an insurance company, 09:43:00
or the degree to which your costs are paid by 09:43:02
private-pay patients? 09:43:04
MR. ORENSTEIN: Objection; 09:43:06
mischaracterizes her testimony. 09:43:06
THE WITNESS: We know that Medicare has a 09:43:12
formula for reimbursement that is lower than other 09:43:20
private-pay carriers. The degree to which that is, 09:43:24
I cannot tell you. 09:43:26

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BY MR. KEMNA:

Q. Is that a general arithmetic formula that applies across the board to whatever treatment is assessed through your office? 09:43:38 09:43:40 09:43:42

A. You would have to ask Medicare or Medicaid how they 09:43:46

calculate their reimbursement to us. 09:43:50

Q. I take it you're pretty much hands-off when it comes to billing for anything related to your treatment of patients at your office? 09:43:56 09:44:00 09:44:02

MR. ORENSTEIN: Objection; vague, mischaracterizes the testimony. 09:44:04 09:44:04

BY MR. KEMNA:

Q. You can answer. 09:44:10

A. I do not put dollar figures in on a billing sheet, if that's what you mean. 09:44:20 09:44:20

Q. You don't put dollar numbers on a billing sheet and, as well, you don't get involved with the coding that is required in order to attain reimbursement from Medicaid or any other company; is that correct? 09:44:30 09:44:34 09:44:40 09:44:42

MR. ORENSTEIN: Objection; mischaracterizes the testimony. 09:44:42 09:44:44

MR. KEMNA: She said yes. 09:44:46

THE WITNESS: I said "that." My word was "that." 09:44:52 09:44:52

BY MR. KEMNA:

Q. And that means? 09:44:56

A. I didn't finish the rest of that sentence. 09:44:58

Q. Okay. And what does that mean? 09:45:02

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A. So now I have to go back to the question because I've forgotten what your question was. That I don't

-- can you repeat the question?

(The requested portion read back.)

MR. ORENSTEIN: Objection; mischaracterizes the testimony, compound question and overbroad.

THE WITNESS: The information that I have, as far as costs for the care of the lung cancer patient, have to do with the approximate costs of the -- of my services and the tests that I order and the drugs that I order for that patient in a broad sense.

And I cannot breakdown for you which insurance companies pay what and in what percentage for what disease.

BY MR. KEMNA:

Q. Do you expect to provide any testimony on a greater level of specificity, as you've just described it, at the trial of this matter?

MR. ORENSTEIN: On what issue?

THE WITNESS: On --

MR. KEMNA: Let her answer the question.

MR. ORENSTEIN: Objection.

THE WITNESS: On the -- to the matter of cost, no. Cost of the care of the lung cancer patient, it will be very vague, broad approximation

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of what the charges are for treatment and care of these patients. 09:46:56 09:46:56

BY MR. KEMNA:

Q. Doctor, in the treatment of patients who come to your office, would you feel comfortable relying upon their self report of what their diagnosis is without the advantage of any other information from medical records or the referral physician? 09:47:38 09:47:42 09:47:48 09:47:52 09:47:54

MR. ORENSTEIN: Objection. 09:47:54

THE WITNESS: No. 09:47:56

BY MR. KEMNA:

Q. Doctor, I think you may have testified to this the other day, but let me ask the question again to make sure I understand. 09:48:40 09:48:44 09:48:46

You would agree that nonsmokers get lung cancer; is that correct? 09:48:52 09:48:52

A. I would agree that there are patients who develop lung cancer that are nonsmokers, yes. 09:49:00 09:49:04

Q. What causes the cancer in nonsmokers? 09:49:14

MR. ORENSTEIN: Objection; lack of foundation. 09:49:16 09:49:16

THE WITNESS: I think you would need to talk with the epidemiologist as far as other risk associated with the development of lung cancer in those patients. 09:49:20 09:49:24 09:49:30 09:49:32

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BY MR. KEMNA:

Q. Would you agree that lung cancer can fairly be described as a multifactorial disease? 09:49:42 09:49:44

MR. ORENSTEIN: Objection. 09:49:48

THE WITNESS: I do not know that I have the -- that I can agree with that statement. 09:49:50 09:49:56

BY MR. KEMNA:

Q. Would you agree that there is more than one risk factor for lung cancer? 09:50:06 09:50:08

A. I think that there are -- that I would agree with that statement that there have been -- epidemiologically they've looked at other factors, but the specifics of those would have to be, again, relied upon the reports of the epidemiologist. 09:50:10 09:50:14 09:50:20 09:50:24 09:50:28

Q. Okay. So you're aware of other risk factors. Which ones are you aware of? 09:50:34 09:50:36

MR. ORENSTEIN: Objection; mischaracterizes her testimony. 09:50:38 09:50:38

THE WITNESS: I would have to rely on the epidemiologic evaluation, and it would be -- I would await their reports. 09:50:44 09:50:52 09:50:54

BY MR. KEMNA:

Q. Okay. Can you identify for me any risk factors for lung cancer? 09:51:00 09:51:02

A. Smoking is felt to be a risk factor for lung cancer. 09:51:10 09:51:10

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Q. Okay. Any other risk factors? 09:51:14
A. Again, I think that we would have to see what the epidemiologic reports say as far as other significant contributing factors to lung cancer. And I'm sure that those are published. 09:51:26 09:51:32 09:51:38 09:51:40
Q. Okay. And so you're not prepared to offer any statement, based upon your background, your experience, your training, regarding any other factor that's been statistically associated with the incidence of lung cancer; is that correct? 09:51:44 09:51:48 09:51:52 09:51:56 09:51:58
A. At this point in time, I would prefer not to. 09:52:10
Q. In a patient who comes to see you and reports on an occupational history that includes exposure to bischloromethyl ether, are you led by that information to make any conclusions regarding what may be responsible for that individual's disease process being lung cancer? 09:52:34 09:52:44 09:52:56 09:53:00 09:53:04 09:53:06
A. In the process of dealing with a medical oncology patient, a patient that comes to you with lung cancer, that information is basically academic and perhaps something that the -- and not necessary in the treatment of the patient or the follow-up of that patient. 09:53:12 09:53:16 09:53:24 09:53:28 09:53:32 09:53:34
So I have no need to speculate as to how 09:53:38

this -- what relationship this process had for the patient. 09:53:46 09:53:46
Q. Okay. So that within an individual patient of yours who reports by history that they had many different 09:53:54 09:54:00

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exposures that have been identified in the literature as risk factors for lung cancer, as well as cigarette smoking, you would not make any attempt at trying to differentiate between those factors regarding what may be responsible for that individual's lung cancer; is that correct? 09:54:04 09:54:10 09:54:16 09:54:20 09:54:22 09:54:24

MR. ORENSTEIN: Objection; assumes facts not in evidence and calls for speculation. 09:54:28 09:54:30

THE WITNESS: Again, when talking about an individual patient, the treatment of that patient's disease is not dependent upon their -- the cause of that disease. It's dependent upon the treatment for the disease they have, what type of cancer they have. They're treated for that type of cancer. 09:54:32 09:54:36 09:54:46 09:54:50 09:54:52 09:54:56

BY MR. KEMNA:

Q. So the answer to my question is that you would not attempt to differentiate between those risk factors regarding what may be responsible for that individual's lung cancer? 09:55:02 09:55:08 09:55:10 09:55:12

A. There would be no reason -- 09:55:14

MR. ORENSTEIN: Same objection. 09:55:14

THE WITNESS: -- to do that speculation. And it would be speculation for an individual. 09:55:18 09:55:20

BY MR. KEMNA:

Q. And so you don't do it? 09:55:20

A. That's correct. 09:55:22

Q. Would you consider yourself in a position to make 09:55:36

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that kind of determination in any setting, either within your practice setting or within the setting of being an expert witness in this lawsuit? 09:55:42 09:55:44 09:55:48

MR. ORENSTEIN: What determination? 09:55:54

THE WITNESS: I'm sorry, I've lost the flow of the question. 09:55:56 09:55:56

MR. KEMNA: The determination that was referred to in the prior question. 09:56:00 09:56:02

MR. ORENSTEIN: Objection. 09:56:04

THE WITNESS: I think, again, when you're talking about individual patients, you cannot make a broad statement about one patient. 09:56:04 09:56:12 09:56:18

BY MR. KEMNA:

Q. Okay, let's talk about populations then, Doctor. 09:56:22

Can you make a broad statement regarding populations rather than an individual patient regarding a differentiation between particular risk factors as to what may be responsible for lung cancer? 09:56:26 09:56:30 09:56:32 09:56:36 09:56:36

MR. ORENSTEIN: Objection; lack of foundation. 09:56:38 09:56:38

THE WITNESS: Again, I would rely on the reports of the epidemiologist looking at population studies and in various risk factors and that would be in the realm of the expert testimony from the epidemiologist. 09:56:42 09:56:44 09:56:50 09:56:54 09:56:56

BY MR. KEMNA:

Q. But not within the realm of the expert testimony 09:56:58

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from you; is that correct? 09:57:00

A. That's correct. 09:57:00

Q. Doctor, is there any test or procedure that can be used to examine a specific tumor of the lung to determine its etiology? 09:57:32 09:57:38 09:57:40

MR. ORENSTEIN: Objection; lack of foundation. 09:57:44 09:57:44

THE WITNESS: The specific tests used to check tumors and make determinations is in the realm of pathology. And the pathologists have a number of tests, but you would have to ask them specifically what tests they would do and the significance of those tests in coming up with their diagnoses. 09:57:50 09:57:54 09:57:58 09:58:02 09:58:04 09:58:08

BY MR. KEMNA:

Q. Doctor, are you aware that the medical literature has reported that the incidence of adenocarcinoma of 09:59:04 09:59:06

the lung has increased over the past 20, 30 some years? 09:59:12 09:59:12

MR. ORENSTEIN: Objection; assumes facts not in evidence. 09:59:16 09:59:16

THE WITNESS: I would have to look at the specific articles that you are referring to. 09:59:20 09:59:24

BY MR. KEMNA:

Q. Have you ever heard of the idea expressed that adenocarcinoma as a cell type of lung cancer is increasing in its proportion of all lung cancers? 09:59:34 09:59:40 09:59:46

A. I have seen graphs that show adenocarcinoma 09:59:54

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increasing at a somewhat faster rate than other types of lung cancer. But I have not reviewed the specific articles used to collect that data. 09:59:58 10:00:02 10:00:06

Q. Is the overall incidence of lung cancer increasing? 10:00:12

MR. ORENSTEIN: Objection; lack of foundation. 10:00:14 10:00:14

THE WITNESS: I would have to, again, look at the data that compared to what patient volume and other cancers that we are seeing. 10:00:20 10:00:28 10:00:30

BY MR. KEMNA:

Q. Doctor, you're aware that there are cancers that occur in the periphery of the lung; is that correct? 10:00:54 10:01:00

A. That is correct. 10:01:00

Q. Are you also aware that the periphery of the lung is predominantly where the cell type adenocarcinoma occurs? 10:01:06 10:01:10 10:01:10

A. I do not know the numbers and percentages of different locations in the lung with respect to different cell types occurring, so I cannot comment on that statement. 10:01:18 10:01:22 10:01:28 10:01:34

Q. Does small cell carcinoma occur commonly in the periphery of the lung? 10:01:38 10:01:38

A. I do not feel that I can answer that question because I do not know the percentages. 10:01:42 10:01:44

Q. Do you have any sense for whether small cell carcinoma is expected to occur in the periphery of the lung versus the central areas of the lung? 10:01:50 10:01:54 10:01:56

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15 A. Statistically, I cannot tell you. I think that in 10:02:00
16 my patient population I see small cell more commonly 10:02:06
17 toward the midline than any periphery. 10:02:12
18 But I cannot tell you statistically if 10:02:14
19 that's relevant because we are dealing with specific 10:02:18
20 patients. 10:02:18
21 Q. Okay. In your clinical experience, where have you 10:02:24
22 most often identified that adenocarcinomas of the 10:02:28
23 lung have occurred? 10:02:28
24 A. They're usually resected by the time I get them. 10:02:34
25 Q. Okay. Is that a pretty good indication that they 10:02:36

1 may be in the periphery of the lung? 10:02:38
2 A. That's -- 10:02:40
3 MR. ORENSTEIN: Objection; calls for 10:02:42
4 speculation. 10:02:42
5 THE WITNESS: That calls for speculation. 10:02:46
6 BY MR. KEMNA:
7 Q. The resectability of a lung tumor is not associated 10:02:54
8 with a peripheral location? 10:02:56
9 A. The resectability of a lung cancer is associated 10:03:02
10 with many factors, in addition to location of 10:03:04
11 tumor. And certainly peripheral lesions are more 10:03:12
12 easily resectable, but not necessarily does that 10:03:16
13 make a person a resectable candidate. 10:03:20
14 Q. Oh, I understand that, Doctor. I mean, individual, 10:03:24
15 by individual you still have to make those 10:03:26
16 assessments that relate to all factors. 10:03:32

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But stepping away from each individual assessment, you're more likely to find resectable tumors in a peripheral location than you are in a central location; would that be correct? 10:03:34 10:03:40 10:03:44 10:03:46

A. I think that's a fair statement. 10:03:48

Q. And you're more likely to find adenocarcinomas of the lung in a peripheral location, rather than a central location; is that correct? 10:03:52 10:03:54 10:03:56

MR. ORENSTEIN: Objection; lack of foundation. 10:03:56 10:03:58

THE WITNESS: I would have to see the numbers, the percentages. 10:04:00 10:04:00

BY MR. KEMNA:

Q. Okay. You can't offer any opinion on that topic? 10:04:04

A. It has been a long time since I've looked at the percentages of location of different cell types of lung cancer and their location in the lung, as that is not something that is a clinical -- of clinical importance in the job of an oncologist. 10:04:06 10:04:14 10:04:18 10:04:22 10:04:26

Q. You're saying that the location of the tumor in the lung gives you no assistance toward a better refinement of the exact diagnosis of the patient? 10:04:34 10:04:38 10:04:40

A. For us -- 10:04:42

MR. ORENSTEIN: Objection; mischaracterizes her testimony. 10:04:42 10:04:44

THE WITNESS: For us, the characterization of the type of tumor is what it looks like under the microscope. For us, that is the information that we 10:04:46 10:04:48 10:05:04

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need. And anything else is speculation and of no clinical importance to us, as far as the tissue type. 10:05:06 10:05:08 10:05:08

BY MR. KEMNA:

Q. If you have a patient that has no cell type diagnosis under the microscope, do you nonetheless go forward with attempting to treat the patient? 10:05:16 10:05:22 10:05:26

A. Not in our office. We would not be getting the patient to be seen unless somebody had made the diagnosis. 10:05:30 10:05:34 10:05:36

So the work-up that you are talking about would be done by someone other than an oncologist, and you would have to ask them their opinion. 10:05:38 10:05:42 10:05:44

Q. Okay. Doctor, let me clarify it because by your answer you must have misunderstood what I was saying. 10:05:50 10:05:52 10:05:52

I was talking about a diagnosis of a particular cell type of lung cancer, not the idea that a malignancy was not identified. 10:05:56 10:05:58 10:06:02

Now, you do recognize that some pathology reports will indicate malignancy without specifying cell type; is that correct? 10:06:06 10:06:10 10:06:10

A. That's correct. 10:06:12

Q. Okay. In that instance, the patient still is going to be treated through an oncology group of some description because of the fact they have a malignancy in the lung; isn't that correct? 10:06:16 10:06:20 10:06:24 10:06:26

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MR. ORENSTEIN: Objection; overbroad. 10:06:28
THE WITNESS: A patient that appears with 10:06:30
that type of diagnosis, we make a very marked 10:06:36
attempt at trying to delineate the cell type to give 10:06:42

them the most appropriate treatment. 10:06:46
If we do not have a specific diagnosis, we 10:06:52
basically can't label them in any other way as just 10:06:58
a carcinoma, if indeed that is the information that 10:07:02
we've been given. 10:07:04
So I'm not sure where you're going on 10:07:08
that. If that is a patient that is a candidate for 10:07:14
surgery, then we would biopsy or operate on that 10:07:18
lesion to better clarify what type of cancer it is. 10:07:26
Q. Let me ask you this question: Are you telling me 10:07:32
that you've never treated a patient, your practice 10:07:38
would never have treated a patient that did not have 10:07:42
a specific cell type of lung cancer diagnosis? 10:07:48
MR. ORENSTEIN: Objection; lack of 10:07:50
foundation, calls for speculation. 10:07:52
THE WITNESS: I cannot tell you anything 10:07:58
specific about the practice in those terms. 10:08:04
BY MR. KEMNA:
Q. Well, in your experience, Doctor, have you ever 10:08:06
treated a patient without a specific cell type 10:08:10
diagnosis in the pathology? 10:08:12
A. We will treat patients with an unknown primary, with 10:08:20
the diagnosis of carcinoma of unknown primary. 10:08:24
We've clarified earlier that there is that 10:08:30

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25 classification that we see occasionally. 10:08:32

1 Q. Okay. Let's take it one step further. You have the 10:08:38
2 opportunity to treat a patient who comes to you with 10:08:44
3 radiological evidence of a mass in the lung. They 10:08:52
4 have been biopsied through bronchoscopic procedure 10:08:56
5 and pathology and cytology assessment of tissue 10:09:02
6 specimens. 10:09:04
7 And across the board from the pathology 10:09:08
8 department, from cytology, you get reports of 10:09:10
9 malignancy. But you otherwise don't have an 10:09:16
10 indication of cell type. 10:09:20
11 If that patient was referred to you and 10:09:22
12 there was no further opportunity for pathology 10:09:26
13 assessment, would you treat that patient? 10:09:28
14 A. I would discuss with the patient some of the 10:09:36
15 treatment options for cancers of unknown primary and 10:09:40
16 the problems fraught with treating a cancer where 10:09:44
17 you do not know where the cell of origin is. 10:09:48
18 Q. So if you don't get a cell type diagnosis of the 10:09:56
19 mass that is viewed within the lung, then you don't 10:10:00
20 know whether that's a primary cancer of the lung; is 10:10:04
21 that what you're saying? 10:10:06
22 A. That's what I'm saying. 10:10:06
23 Q. And that has happened in your practice, hasn't it? 10:10:18
24 A. I cannot think of a specific patient where that has 10:10:20
25 happened. 10:10:20

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Q. Okay. 10:10:22
A. So I cannot say that that has happened in my practice. But that would -- I'm just telling you what the method would be to address that issue in a patient that would appear that way. 10:10:26 10:10:30 10:10:36 10:10:38
Q. Would you agree, Doctor, that in making a final determination of whether -- well, what the specific disease process is in a patient, that is best determined by pathology assessment by virtue of autopsy? 10:10:46 10:10:50 10:10:58 10:11:04 10:11:04
MR. ORENSTEIN: Objection; overbroad, vague. 10:11:08 10:11:08
THE WITNESS: I'm not sure exactly what the question is. You would have to make it more specific. 10:11:12 10:11:16 10:11:16
BY MR. KEMNA:
Q. You have information available to you as a practitioner in the field of oncology and as a part of the treatment group dealing with lung cancer patients, and there are indicators regarding the diagnosis of that patient through the course of the treatment process; is that correct? 10:11:22 10:11:26 10:11:30 10:11:36 10:11:40 10:11:42
A. That is correct. 10:11:46
Q. And you make your best determination based upon the information available to you during the course of 10:11:52 10:11:54

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treatment as to what the appropriate diagnosis is for the patient; is that correct? 10:11:56 10:11:58

MR. ORENSTEIN: Objection. 10:11:58

THE WITNESS: We use pathologic evaluation and x-ray evaluation to determine what the condition of the patient is, yes. 10:12:04 10:12:08 10:12:10

BY MR. KEMNA:

Q. But ultimately, and this is unfortunate with respect to lung cancer patients, but they tend not to have a good prognosis in quite a number of cases, so they die. 10:12:16 10:12:22 10:12:28 10:12:28

And if an autopsy is performed, the autopsy is an opportunity for a total body examination of whatever disease process may be at play; is that correct? 10:12:32 10:12:36 10:12:40 10:12:40

MR. ORENSTEIN: Objection; overbroad, lack of foundation. 10:12:44 10:12:44

THE WITNESS: You'd have to talk with a pathologist as far as what information they feel that they glean from autopsies. 10:12:46 10:12:50 10:12:54

BY MR. KEMNA:

Q. So you have no view regarding whether an autopsy is the best opportunity to determine exactly what disease process is occurring within any individual patient? 10:12:58 10:13:02 10:13:06 10:13:06

A. In our particular practice, it is of no benefit because we cannot do anything to help the patient at 10:13:14 10:13:16

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that juncture. 10:13:18

Q. Well, Doctor, that's really not the question. And I understand the nature of your practice. The question is designed to get to whether you regard autopsy as the most reliable method to determine exactly what is the diagnosis in a particular patient? 10:13:22 10:13:26 10:13:30 10:13:34 10:13:40 10:13:40

MR. ORENSTEIN: And objection, lack of foundation, and outside the scope of her expert testimony. 10:13:42 10:13:46 10:13:46

THE WITNESS: I would think that to talk with a pathologist to get an idea of how often their diagnoses is changed with autopsy would be a more appropriate evaluation. I have no opinion on that. 10:13:50 10:13:54 10:13:58 10:14:04

BY MR. KEMNA:

Q. Well, are you aware, Doctor, that the accuracy of clinical diagnoses of cancer is compared against autopsy results to determine the level of accuracy of diagnosis? 10:14:10 10:14:18 10:14:22 10:14:24

A. I have not seen those studies. 10:14:26

Q. Are you aware of those studies? 10:14:28

A. No. 10:14:30

Q. Do you have any sense on the level of agreement or 10:14:36

disagreement between clinical diagnoses and autopsy diagnoses of lung cancer? 10:14:40 10:14:44

A. I have no idea of what the correlation is and who is making the correlation. Although, studies are done. Where the data comes from, I have no 10:14:50 10:14:52 10:14:56

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information on that. 10:14:56

Q. Doctor, are you familiar with the Cancer Prevention Study conducted by the American Cancer Society? It's generally known as CPS-2. 10:15:06 10:15:08 10:15:12

A. I'm not involved in that study. 10:15:14

Q. Okay. You're affiliated with the American Cancer Society; is that correct? 10:15:20 10:15:22

A. That's correct. 10:15:22

Q. But you've never heard of that particular study; is that correct? 10:15:26

A. Yes. 10:15:28

MR. ORENSTEIN: Objection; mischaracterizes the testimony. 10:15:28 10:15:30

BY MR. KEMNA:

Q. Is your answer yes? 10:15:30

A. I said I did not participate in that study. I do not know the details of that study. 10:15:34 10:15:36

Q. Okay. And my follow-up question was to find out if you actually knew about the study? 10:15:40 10:15:42

A. I have heard that there is such a study. I do not 10:15:46

know the details of that study. 10:15:48

Q. Are you aware of what type of information was used in order to compile data on cause of death in the CPS-2 study conducted by the American Cancer Society? 10:15:58 10:16:04 10:16:08

A. I think I just got through saying that I do not know any of the mechanisms, the methodology and such of 10:16:12 10:16:18

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that study, no. 10:16:18

MR. ORENSTEIN: Counsel, would this be a 10:16:52
good time to take a break? 10:16:52

MR. KEMNA: Sure. 10:16:54

THE VIDEOGRAPHER: The time is now 10:16. 10:16:56
And this is the end of the third videotape in 10:17:00
Dr. Bowers' testimony. 10:17:02

(Off the record.) 10:17:04

THE VIDEOGRAPHER: We're back on the video 10:36:22
record. The time is now 10:36 a.m. And this is the 10:36:26
beginning of the fourth videotape in testimony given 10:36:30
by Dr. Bowers. 10:36:30

BY MR. KEMNA:

Q. Doctor, I want to ask you a couple of questions 10:37:08
about sort of the practical consequences of 10:37:14
diagnoses that occur in medical records, perhaps 10:37:16
outside your particular scope of office setting and 10:37:20
oncology, for instance. 10:37:22

But if a patient is hospitalized and they 10:37:34
have multiple conditions that present themselves in 10:37:40
the hospital and diagnoses are made, would you 10:37:44
expect for the billing associated with the 10:37:52
hospitalization to include multiple billing codes 10:37:56
reflecting each and every diagnosis made? 10:38:00

MR. ORENSTEIN: Objection; lack of 10:38:02
foundation, calls for speculation, beyond the scope 10:38:06
of her expert testimony. 10:38:08

THE WITNESS: I believe you would have to 10:38:12

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check with the billing department of the hospital as to how they code for charges in the hospital. 10:38:16 10:38:22

BY MR. KEMNA:

Q. Okay. So you don't really have any personal knowledge of any billing practices that might apply in a hospital setting; is that correct? 10:38:26 10:38:34 10:38:36

A. We don't do any billing through the hospital and have no control over how they bill or what the rules that govern their billing are. 10:38:40 10:38:44 10:38:46

Q. Okay. Without having any control over the billing, do you, nonetheless, have knowledge of how they go about the billing for services in a hospital setting? 10:38:50 10:38:56 10:39:00 10:39:00

A. I do not have knowledge on how they go about billing in the hospital setting, other than the fact that we 10:39:06 10:39:10

need to have a complete medical record and each physician that sees a patient needs to dictate a note with the diagnoses. 10:39:16 10:39:22 10:39:24

And that if the diagnoses that they are seeing the patient for is not written in some form on the chart, they resubmit the chart to you for clarification of what you have done in the hospital. 10:39:26 10:39:32 10:39:38 10:39:42 10:39:42

But exactly how they use that or how they code, et cetera, I'm not sure. 10:39:46 10:39:48

Q. If a patient was referred to you, Doctor, and all you had access to were a list of diagnostic codes 10:39:54 10:40:04

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that had been used in a previous treatment setting, would you feel comfortable with that being the basis of information for you to provide treatment for that patient? 10:40:14 10:40:16 10:40:22 10:40:22

MR. ORENSTEIN: Objection; ambiguous, overbroad. 10:40:24 10:40:26

THE WITNESS: I wouldn't even know what to do with those codes if all I got were codes. 10:40:28 10:40:30

BY MR. KEMNA:

Q. Okay. If you had the list of codes reflecting previous diagnoses on the patient from whatever treatment setting, and you had a sheet that would allow you to translate from a billing number code to 10:40:36 10:40:40 10:40:48 10:40:52

the corresponding diagnosis, could you rely upon the diagnoses arrived at through that method? 10:40:58 10:41:02

MR. ORENSTEIN: In treating patients? 10:41:04

MR. KEMNA: Yes. 10:41:06

THE WITNESS: We require that we have a pathology report that is signed by a pathologist to treat patients. 10:41:10 10:41:14 10:41:16

BY MR. KEMNA:

Q. Okay. So you would not rely on any other source of information to arrive at the exact diagnosis for a patient for lung cancer, for instance? 10:41:22 10:41:26 10:41:28

MR. ORENSTEIN: Objection; mischaracterizes her testimony. 10:41:30 10:41:30

THE WITNESS: Again, we need to specify whether we are talking about a large group of 10:41:38 10:41:40

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patients or a specific patient. 10:41:44

But, obviously, for a specific patient, 10:41:46

you need to tailor their treatment to their 10:41:52

diagnoses, and you need to get all of the 10:41:54

information you can as accurately as possible and 10:41:58

completely as possible for your records. 10:42:00

BY MR. KEMNA:

Q. Okay. That is to assure that you have all the 10:42:08

necessary information to form some conclusion about 10:42:10

diagnoses; is that correct? 10:42:12

MR. ORENSTEIN: For treatment purposes? 10:42:14

THE WITNESS: For treatment purposes for 10:42:18

that patient, you need to know what the patient has 10:42:20

had done as far as diagnostic procedures, their past 10:42:28

diagnoses, so you can decide whether their work-up 10:42:32

has been complete. 10:42:34

And the only way you can do that is to get 10:42:36

the actual reports to see what has been done, not 10:42:40

just the conclusion of those reports. 10:42:42

BY MR. KEMNA:

Q. Doctor, do you sometimes interview patients referred 10:43:32

to you and find that they have an incomplete 10:43:36

understanding of the nature of their diagnosis? 10:43:42

MR. ORENSTEIN: Objection; vague and 10:43:46

overbroad. 10:43:46

THE WITNESS: I think I would need to know 10:43:52

what you mean by an incomplete understanding of 10:43:56

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their diagnosis and what specific patient you are talking about. 10:44:00 10:44:00

BY MR. KEMNA:

Q. Have you ever interviewed a patient that was mistaken about the diagnosis that is otherwise identifiable by you through medical records and contact with the prior treating physician? 10:44:06 10:44:12 10:44:16 10:44:18

A. I cannot think of any specific case where, you know, 10:44:36

that would fulfill those criteria. But I think it's a little vague for me to put a face to that particular patient in my mind. 10:44:40 10:44:42 10:44:46

Q. Okay. Well, actually, at least for my purposes, you don't need to sort of seek through your memory some particular face to apply to a response to the question. It really gets at your general experience in treating patients. 10:44:50 10:44:56 10:44:58 10:45:02 10:45:06

If you have a patient that comes into your office by referral from another physician, and you're discussing with the patient matters related to treatment, do they ever indicate to you that they believe they have a condition that you feel there is no documentation to establish that they indeed have that condition? 10:45:08 10:45:10 10:45:16 10:45:20 10:45:24 10:45:26 10:45:28

MR. ORENSTEIN: Objection; calls for speculation, assumes facts not in evidence. 10:45:28 10:45:32

THE WITNESS: Again, we discuss with the patient their path report. They most often know what their path report is. I mean, that's why 10:45:34 10:45:38 10:45:40

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they're there. They usually have a copy or are carrying their path report on their person. 10:45:44 10:45:46

BY MR. KEMNA:

Q. Okay. Let's look to a particular hypothetical example. If a patient comes to you and they're 10:45:54 10:46:02

aware of a pathology report that says that they have a nonsmall cell cancer and it was identified in their lung, would you be surprised if that patient told you that they had lung cancer? 10:46:08 10:46:14 10:46:20 10:46:22

A. I wouldn't necessarily be surprised if they told me that they had lung cancer or they had liver cancer or, you know, whatever, depending upon where their biopsy came from. 10:46:30 10:46:34 10:46:38 10:46:42

But whether that's really what they meant as far as their true understanding of the disease -- in other words, people will make statements like that. 10:46:44 10:46:54 10:46:56 10:46:56

On further questioning, they have a much broader understanding of what they're dealing with and what is known and what is not known about their pathologic diagnoses. 10:46:58 10:47:00 10:47:04 10:47:06

Q. Okay. If a patient says to you they have lung cancer, do you rely on that information to indicate to you that they have a primary cancer of the lung? 10:47:16 10:47:22 10:47:24

MR. ORENSTEIN: Objection; calls for speculation, assumes facts not in evidence. 10:47:26 10:47:28

THE WITNESS: I would have to -- again 10:47:32

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you're talking about a specific patient. But as we talked before, we do not make decisions on the basis of somebody's verbiage that I have lung cancer. We

need other information.

BY MR. KEMNA:

Q. Do you think it is feasible for a patient under the circumstances of knowing of a pathology report that they have a nonsmall cell carcinoma of the lung, identified in the lung, represent to you that they have lung cancer when, in fact, it may be a metastases from some other site in the body?

MR. ORENSTEIN: Objection; calls for speculation.

THE WITNESS: I would have to see the medical records of that person and to see what they may or may not expect and what their true thought process is.

BY MR. KEMNA:

Q. Certainly you need confirmation from a variety of other sources of information to make a determination on that patient's true condition, other than the patient's understanding of what their condition is; is that true?

MR. ORENSTEIN: For treatment purposes?

BY MR. KEMNA:

Q. Any purpose.

MR. ORENSTEIN: Objection; lack of foundation.

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THE WITNESS: Definitely for treatment purposes, we need more information. 10:49:22 10:49:22

BY MR. KEMNA:

Q. Okay. For any other purpose would you need any more information to determine what the true diagnosis of the patient is? 10:49:30 10:49:32 10:49:32

MR. ORENSTEIN: Objection; overbroad, lack of foundation, beyond the scope of her expert testimony. 10:49:34 10:49:38 10:49:38

THE WITNESS: If I am treating a patient, I need to have more information. I cannot speculate in any other situation what would be necessary, you know, for that patient. 10:49:44 10:49:48 10:49:54 10:49:56

BY MR. KEMNA:

Q. Let's say you were attempting to make a study of what proportion of costs in treating cancer is comprised of by treating primary cancer of the lung? 10:50:02 10:50:08 10:50:12 10:50:12

A. I would have to have -- 10:50:16

MR. ORENSTEIN: Objection; lack of foundation, calls for speculation, beyond the scope of her expert testimony. 10:50:20 10:50:24 10:50:24

MR. KEMNA: Howard, is it your understanding that all objections are preserved except as to form, and that it is really not 10:50:26 10:50:30 10:50:32

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necessary to specify a number of bases for objections in deposition? 10:50:36 10:50:38

MR. ORENSTEIN: No, the court order anticipates that the attorney may specify the nature of the objection, so long as it's -- it doesn't venture over into the area of coaching the witness. 10:50:40 10:50:44 10:50:46 10:50:50

MR. KEMNA: And you don't believe you're venturing over into the area of coaching the witness? 10:50:52 10:50:54 10:50:54

MR. ORENSTEIN: Absolutely not. My objections are entirely consistent with the objections that have been made by both sides throughout the course of the litigation. 10:50:58 10:51:00 10:51:04 10:51:06

THE WITNESS: People who set up studies and collect data do have other areas of training to look at what is significant in putting forth data collecting information. And I've never been involved in any such study, thus I do not feel that I have the expertise to answer that any more specifically. 10:51:12 10:51:18 10:51:24 10:51:26 10:51:32 10:51:36 10:51:36

BY MR. KEMNA:

Q. You cannot even speak to the basic question of whether or not you would want all information available necessary to make a determination as to whether the cancer is a primary or a metastases to 10:51:48 10:51:50 10:51:52 10:51:56

the lung? 10:51:56

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MR. ORENSTEIN: Objection, same objection, overbroad, beyond the scope of her expert testimony, lack of foundation. 10:52:00 10:52:04 10:52:04

THE WITNESS: Again, I would have to -- it would depend on what the study was trying to show and what types of, I guess, corrections they were making. I cannot venture any guess on that question as to what they really need and what their -- the format of their study was. 10:52:08 10:52:10 10:52:18 10:52:26 10:52:32 10:52:34

BY MR. KEMNA:

Q. It isn't apparent to you, from the basis of the hypothetical, that in studying the relative contribution of the treatment of primary cancer of the lung to all treatment costs associated with cancer generally that you wouldn't be interested in delineating between those particular cases that would be a primary cancer of the lung versus a metastases to the lung? 10:52:38 10:52:42 10:52:44 10:52:48 10:52:52 10:52:58 10:53:02 10:53:04

A. I'm not even sure they haven't delineated. I don't know, I have no idea of what the format of the study would be. 10:53:08 10:53:10 10:53:10

MR. ORENSTEIN: Objection. 10:53:12

BY MR. KEMNA:

Q. Well, surely, Doctor, you would recognize that the 10:53:16

way to conduct a study in the first place is to collect the appropriate information to categorize the data in one set representing primary cancers of 10:53:18 10:53:22 10:53:28

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the lung and the whole set that's inclusive of the treatment of all cancer? 10:53:34 10:53:36

MR. ORENSTEIN: Objection; argumentative, overbroad, calls for speculation, calls for opinion outside the scope of her testimony, lack of foundation. 10:53:38 10:53:42 10:53:44 10:53:46

THE WITNESS: Again, there are specific questions that are answered in any study or asked in any study to be answered, and there's a methodology that they put forth to obtain the data and analyze the data. Unless you are versed in those methods, it is impossible to answer that question. 10:53:52 10:53:54 10:53:58 10:54:02 10:54:08 10:54:14

BY MR. KEMNA:

Q. Did you ever study in medical school or otherwise in your training how they conduct epidemiological studies? 10:54:18 10:54:24 10:54:24

A. No. 10:54:24

Q. Didn't address that at all in any aspect of your education and training? 10:54:28 10:54:30

A. I did not take any courses on epidemiology and the epidemiologic methodology. 10:54:32 10:54:38

Q. Do you have an understanding of how those studies 10:54:46

are conducted and the degree to which you can rely on results from those studies toward identifying any factors or risk factor for disease? 10:54:50 10:54:54 10:54:58

MR. ORENSTEIN: Objection; overbroad, compound question. 10:55:00 10:55:00

THE WITNESS: Very peripherally, in the 10:55:06

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association with the epidemiologist, the statisticians give us -- we need to rely on people with those -- in those areas of expertise. 10:55:08 10:55:14 10:55:18

We cannot be -- we cannot judge, as individual clinicians, every bit of information that comes across epidemiologically, but we have to rely on the statistics and people in the field looking at the methodology. 10:55:24 10:55:30 10:55:36 10:55:52 10:55:52

BY MR. KEMNA:

Q. Are you able to differentiate between what you would regard as a reliable epidemiological study versus a study that has serious limitations in methodology and procedure? 10:55:52 10:55:56 10:56:02 10:56:02

MR. ORENSTEIN: Objection; overbroad, calls for speculation. 10:56:04 10:56:06

THE WITNESS: I would be speculating if I answered that question. And I'd have to look at the specific studies to see if there were things that I could identify. But I'm not an expert in that area, 10:56:08 10:56:10 10:56:18 10:56:20

so it would definitely be a reach. 10:56:24

BY MR. KEMNA:

Q. Acknowledging that you're not an expert in the area, but you are a physician and you do review medical literature, do you have a knowledge base necessary to distinguish between what would be regarded as a reliable and well-done study versus a study that deserves no real recognition within the medical 10:56:28 10:56:34 10:56:38 10:56:42 10:56:48 10:56:50

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community? 10:56:52

MR. ORENSTEIN: Objection; overbroad, 10:56:54

vague. 10:56:54

THE WITNESS: In relationship to things 10:56:58

that are on the epidemiologic basis, again, we see 10:57:04

in the medical literature, when we read any report, 10:57:10

they talk -- have a section on the epidemiology that 10:57:20

is basically an overview. 10:57:24

And our only, I guess, opinion, or not 10:57:28

opinion, but response would be as to whether the 10:57:36

epidemiology that they were quoting seemed to be 10:57:40

consistent with what we saw in practice or not. 10:57:44

That is not a scientific approach nor one 10:57:50

that can be quantified. 10:57:52

BY MR. KEMNA:

Q. Doctor, has your office -- well, let me broaden that 10:58:36

question to any office that you've been affiliated 10:58:38

with. 10:58:40

Has your offices -- have your offices ever 10:58:48

been audited by any medical reimbursement provider 10:58:56

for the accuracy of billing practices? 10:59:00

MR. ORENSTEIN: Objection; vague and 10:59:04

overbroad. 10:59:04

THE WITNESS: I wouldn't have any idea. 10:59:06

BY MR. KEMNA:

Q. So, for instance, if mistakes were being made in 10:59:20

assigning codes for reimbursement of medical costs 10:59:26

respecting particular diagnoses made by you or 10:59:30

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anyone in your practice setting, you would not know about any error rate that would be identified between the billing and the diagnoses? 10:59:38 10:59:42 10:59:44

MR. ORENSTEIN: Objection; assumes facts not in evidence. 10:59:48 10:59:48

THE WITNESS: I do not work in the business office in our practice and would not have any knowledge. 10:59:54 11:00:00 11:00:00

BY MR. KEMNA:

Q. Doctor, do you ever refer any of your lung cancer patients to a nursing home setting for follow-up care? 11:00:20 11:00:24 11:00:26

A. May I rephrase your question? You don't refer patients to nursing homes for follow-up care. 11:00:38 11:00:40

Q. Okay. You can clarify it whatever way. 11:00:42

A. We have many of our patients end up in nursing homes for supportive services for their disease. They have increasing problems that require more sophisticated medical attention frequently than what can be given at home. 11:00:54 11:01:02 11:01:06 11:01:10 11:01:12

And in those situations, may need to be sent to a nursing home for that care, for that more aggressive care. 11:01:16 11:01:24 11:01:26

Q. What types of supportive services would be desirable in a nursing home setting for the follow-up care of a lung cancer patient? 11:01:34 11:01:36 11:01:38

A. Well, most of the patients that we send to nursing 11:01:40

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homes will need nursing care to adjust their pain medications, watch their oxygenation, help with muscle strengthening, help with feeding. 11:01:44 11:01:52 11:02:00

Perhaps help just with transferring in and out of bed, to the bathroom, and basic needs, depending upon the state of their disease at that time. 11:02:04 11:02:10 11:02:16 11:02:16

Q. Are patients that are referred to a nursing home setting often afflicted with some other aspect of either the disease process or some other infirmity that they are either physically or mentally incapacitated? 11:02:20 11:02:26 11:02:32 11:02:36 11:02:36

MR. ORENSTEIN: Objection; vague and overbroad, compound question. 11:02:40 11:02:42

THE WITNESS: Patients don't go to nursing homes unless they have significant needs to be in those nursing homes. They would live independently. So they obviously have multiple needs that may not be able to be met in a home situation. 11:02:48 11:02:54 11:02:56 11:03:00 11:03:06 11:03:06

BY MR. KEMNA:

Q. Okay. What proportion of patients that you deal with in your practice would you say are treated on an outpatient basis? 11:03:10 11:03:16 11:03:18

MR. ORENSTEIN: Objection; lack of foundation. 11:03:22 11:03:22

THE WITNESS: Again, I would not have a specific number and you would have to clarify the 11:03:24 11:03:32

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term outpatient basis and treatment because all of those things have varying meanings to me. 11:03:36 11:03:40

BY MR. KEMNA:

Q. Okay. Is it fair to say that use of the term "outpatient" would refer to someone who is receiving treatment and is not requiring of inpatient status in some treatment setting? 11:03:44 11:03:48 11:03:54 11:04:02

A. That's not the way we use the term. 11:04:06

Q. Okay. Would you define the term "outpatient." 11:04:10

A. Outpatient is someone that is being treated in a setting other than an acute hospital setting. 11:04:14 11:04:18

Q. Okay. So that within the category of outpatient settings, you would include a nursing home? 11:04:24 11:04:28

A. Extended care, nursing home, home hospice. 11:04:32

Q. Would you say it is rare for patients of yours being treated for lung cancer to be treated in a nursing home setting? 11:04:40 11:04:46 11:04:46

MR. ORENSTEIN: Objection; ambiguous. 11:04:52

THE WITNESS: I guess I would -- no one ever gets specific treatment within the nursing home. They would come into the hospital or the office to be treated. 11:04:54 11:04:56 11:05:00 11:05:02

BY MR. KEMNA:

Q. Okay. Then would you say that it is rare for lung cancer patients of yours to have their living environment be a nursing home versus other living environments outside of an inpatient hospital 11:05:08 11:05:14 11:05:22 11:05:24

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setting? 11:05:24

MR. ORENSTEIN: Objection; ambiguous. 11:05:28

THE WITNESS: I cannot put a number, 11:05:32
percentage of the lung cancer patients that live at 11:05:34
home or live in a nursing home. 11:05:36

Both situations, we see both situations, 11:05:40
where people will be in a nursing home or they will 11:05:42

be living at home. And I cannot tell you what 11:05:46
percentage fall into what category. 11:05:48

BY MR. KEMNA:

Q. Relatively speaking -- 11:05:50

A. I don't think -- 11:05:52

Q. -- would it be more in a home setting versus a 11:05:56
nursing home setting? 11:05:56

A. I think it depends on so many factors other than 11:06:00
their disease. I don't know that I can say that. 11:06:02

Q. What factors, other than their disease, account for 11:06:06
these patients being in a nursing home setting? 11:06:10

A. Basically family and the ability of family to care 11:06:16
for them if they need. I mean, there are people 11:06:20
with very extensive medical problems that are at 11:06:22
home because they have family that's capable of 11:06:26
taking care of them. 11:06:26

Other people with less extensive disease 11:06:30
need a nursing home just because they have no one to 11:06:36
even take care of some of the minor problems. So, I 11:06:40
mean, it's a very mixed population and you cannot 11:06:42
make generalities. 11:06:48

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Maybe someone has figures, but I don't have those figures and do not sense that there's, I guess, a standard or a usual. 11:06:50 11:06:56 11:06:56

Q. Doctor, are you equating a nursing home setting with a hospice setting? 11:07:02 11:07:04

A. No. 11:07:04

Q. The two are distinctly different; is that right? 11:07:08

A. A hospice is a philosophy and not a place. 11:07:12

Q. Is it your understanding that most hospice programs are designed to deal with the patient in whatever living condition they are in? 11:07:18 11:07:24 11:07:26

A. That is correct. 11:07:28

Q. Would you agree that some individuals that find it necessary to be in a nursing home setting are there because of some type of mental incapacity, for example, dementia? 11:07:46 11:07:48 11:07:54 11:07:56

MR. ORENSTEIN: Objection, lack of foundation. 11:07:58 11:08:00

THE WITNESS: I think that you would have to look at statistics as to what percentage of patients are in nursing homes for dementia. I do not know what percentage of nursing home patients in this state or in this country are there for dementia. 11:08:02 11:08:04 11:08:08 11:08:12 11:08:18 11:08:18

BY MR. KEMNA:

Q. Do you know at least some of them are in a nursing home for that reason? 11:08:20 11:08:22

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MR. ORENSTEIN: Objection; lack of foundation and beyond the scope of her testimony. 11:08:22 11:08:26

THE WITNESS: Basically that's -- do people go to nursing homes for dementia? Ask anyone on the street. We all would say yes to that. But that's not a medical -- I mean, it has no -- I have no numbers or opinion on that. 11:08:28 11:08:34 11:08:36 11:08:44 11:08:48

BY MR. KEMNA:

Q. Are you familiar with Alzheimer's disease, Doctor? 11:08:52

A. Yes. 11:08:52

Q. Are you familiar that Alzheimer's disease accounts for a significant amount of dementia in elderly people? 11:08:56 11:09:04 11:09:04

MR. ORENSTEIN: Objection; beyond the scope of her expert testimony. 11:09:06 11:09:08

Are you going to continue to try to depose her about a lot of things that aren't in her report? Because we're getting close to the point where I'm going to call the judge about it. 11:09:10 11:09:14 11:09:16 11:09:20

She is here to testify about certain things related to oncology, on cancer, what's described in her report. And you're getting far-field here. 11:09:22 11:09:28 11:09:30 11:09:32

I want to caution you about that and put on the record, just so you're aware, that I consider it inappropriate at this point and I may call the judge about it. 11:09:36 11:09:38 11:09:42 11:09:42

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MR. KEMNA: Well, you do what you think you have to do, Howard. 11:09:44 11:09:46

But you would agree that a significant aspect of this lawsuit has to do with the assessment of certain types of costs in a treatment setting and the attribution of cost to smoking. 11:09:50 11:09:54 11:10:02 11:10:04

And there are a lot of aspects involved in assessing what types of costs may be attributable to cigarette smoking, including treatment settings that are connected with the diagnosis that Dr. Bowers is here to speak to. 11:10:08 11:10:14 11:10:18 11:10:22 11:10:24

Now, whether you've anticipated it within the expert report, itself, is not my concern. My interpretation of the scope of her testimony includes what I am asking her questions about. 11:10:28 11:10:34 11:10:36 11:10:38

MR. ORENSTEIN: Well, the lawsuit relates to a lot of things and there are experts that will testify on both sides about many of those things. She's here to testify about what's in her report. 11:10:40 11:10:44 11:10:46 11:10:48

MR. KEMNA: Which relates to the costs associated with the treatment of lung cancer, correct? 11:10:52 11:10:56 11:10:56

MR. ORENSTEIN: Yes, and you're asking her about Alzheimer's disease. I'm telling you you're getting to the point where I think you're way beyond 11:10:58 11:11:04 11:11:06

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the scope of the report and what she's here to testify about. 11:11:08

MR. KEMNA: And that -- 11:11:12

MR. ORENSTEIN: I have allowed you a fair amount of latitude, I think you'd have to concede. I'm not going to allow you to try and make her an expert on every aspect of the lawsuit. 11:11:14 11:11:22 11:11:24 11:11:24

MR. KEMNA: I'm not interested in making her an expert. I'm interested in discussing what potentially falls within the scope of testimony she intends to provide at trial. 11:11:26 11:11:26 11:11:30 11:11:32

MR. ORENSTEIN: Well, questions about Alzheimer's disease, I think, are outside the scope. 11:11:34 11:11:36 11:11:36

MR. KEMNA: Are you representing that patients with lung cancer or patients within a nursing home setting would have no bearing on the incidence of Alzheimer's disease or have any bearing on the question of whether smoking is associated with any of those costs? 11:11:44 11:11:48 11:11:52 11:11:56 11:12:00 11:12:02

MR. ORENSTEIN: I don't even understand your question, so why don't you continue the deposition. I've warned you that I think you're beyond the scope of your expert report. 11:12:04 11:12:06 11:12:10 11:12:12

MR. KEMNA: I've heard the warning -- 11:12:14

MR. ORENSTEIN: You're trying to make her an expert on lateral subjects. 11:12:16 11:12:18

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MR. KEMNA: -- and I've heard the nature of the objections, and there's no question in my mind that you are raising the issue. 11:12:20 11:12:20 11:12:22

MR. ORENSTEIN: Good.

BY MR. KEMNA:

Q. Doctor, in your treatment of lung cancer patients, have you noticed a change in the nature of the treatment provided to those patients as a function of time? 11:13:08 11:13:10 11:13:16 11:13:16

MR. ORENSTEIN: Objection; ambiguous. 11:13:22

THE WITNESS: There have been some improvements in treatment and changes in certain treatment modalities available in chemotherapy and radiation therapy, diagnostic procedures over the years I've been in medicine, if that's what you're referring to. 11:13:26 11:13:34 11:13:40 11:13:46 11:13:48 11:13:48

BY MR. KEMNA:

Q. Let's talk, for example, about the relative proportion of lung cancer patients that may be treated by surgery versus nonsurgical treatment modalities. 11:13:56 11:13:58 11:14:04 11:14:08

Have you noticed a change in that balance over time? 11:14:10 11:14:12

MR. ORENSTEIN: Objection; ambiguous. 11:14:14

THE WITNESS: I don't know that there is a change in percentage of patients that actually end up going to surgery and having surgery over the 11:14:16 11:14:22 11:14:28

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years that I've been practicing. You know, I don't know if there is a statistical difference in that percentage. 11:14:32 11:14:34 11:14:36

BY MR. KEMNA:

Q. Do you believe that small cell carcinoma is treatable by surgery? 11:14:46 11:14:48

A. Small cell is not considered a surgically resectable cancer. Although, some people end up having small cell cancer resected to make the diagnosis, and it's not until after the lesion is resected that we know that they have small cell carcinoma of the lung. 11:14:54 11:15:00 11:15:04 11:15:06 11:15:10

Q. Have you recognized in the literature where the mind set that small cell carcinoma of the lung may not be subject to surgical intervention is changing toward perhaps a more aggressive stance in actually surgically treating small cell carcinoma of the lung? 11:15:14 11:15:18 11:15:22 11:15:26 11:15:30 11:15:30

MR. ORENSTEIN: Objection; overbroad and calls for speculation. 11:15:32 11:15:34

THE WITNESS: I cannot talk to you about the trend. Are there individual reports that talk 11:15:38 11:15:46

about the surgical excision of small cell carcinomas? 11:15:52 11:15:52

There are some reports that appear in the literature that is not considered at this point in time the standard of care for small cell. It's still an investigational approach looking at the subgroups of patients. 11:15:56 11:16:02 11:16:08 11:16:10 11:16:14

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BY MR. KEMNA:

Q. In your role as an oncologist, is your treatment of lung cancer patients restricted mostly to the prescribing and administration of chemotherapeutic agents? 11:16:32 11:16:40 11:16:46 11:16:48

A. We will -- as an oncologist, we see the patient, we make sure that all of the staging evaluation has been done with the bone scans, CT scan, laboratory evaluation. 11:16:56 11:17:00 11:17:04 11:17:06

We make sure that unless it is readily obvious they have metastatic disease, that they are evaluated by pulmonary, thoracic surgery and radiation therapy to get their expert opinions as to the patient's likelihood of responding to any of those modalities. 11:17:10 11:17:12 11:17:18 11:17:22 11:17:30 11:17:30

Q. Do you apply radiation therapy to any of your patients? 11:17:48 11:17:48

A. I do not. 11:17:50

MR. ORENSTEIN: Does she personally apply it? 11:17:52

THE WITNESS: I do not give radiation therapy, no. There are people who are specialists in radiation therapy that do that. 11:17:52 11:17:56 11:18:02

BY MR. KEMNA:

Q. Okay. They would generally be referred to as radiation oncologists? 11:18:08 11:18:08

A. Radiation therapist, radiation oncologists, yes. 11:18:12

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Q. So that aspect of the treatment of lung cancer is not something that you're directly involved with? 11:18:18 11:18:22
A. No, there are experts in that area that deal with that. 11:18:26 11:18:26
Q. Are you familiar with the costs associated with applying radiation therapy in the treatment of lung cancer? 11:18:30 11:18:36 11:18:36
A. I do not know the dollar amount of an average course of radiation therapy, no. 11:18:42 11:18:42
Q. Is the treatment of lung cancer by radiation therapy included within your estimate of costs on an annual basis for treatment of lung cancer? 11:18:52 11:18:56 11:19:00
A. In a broad sense, yes. 11:19:02
Q. If you're not aware of the average cost of radiation therapy for treating of lung cancer patients, in what sense could you add that to whatever other 11:19:12 11:19:18 11:19:22

costs that you are personally associated with in the treatment of lung cancer? 11:19:26 11:19:28
A. Basically patients saying that this cost them several thousand dollars, or the bills were several thousand dollars for this. 11:19:32 11:19:36 11:19:40
But, again, what -- how the breakdown of that was and the specific amount even for a given patient, let alone for an average course, obviously, patients' courses differ somewhat as far as even in the cost of a given course of chemotherapy. 11:19:52 11:19:52 11:19:52 11:19:58 11:20:02
Q. Doctor, do you perform surgical procedures on lung cancer patients? 11:20:10 11:20:12

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A. I perform no surgical procedures. 11:20:14
Q. And as we discussed with the administration of radiation therapy, you, likewise, would refer to someone else as a specialist to deal with surgical intervention with a lung cancer patient; is that correct? 11:20:24 11:20:34 11:20:38 11:20:42
A. That's correct. 11:20:42
Q. Are you personally familiar with the costs associated with the surgical treatment of lung cancer? 11:20:46 11:20:50 11:20:50
A. I do not know the average cost of a surgical procedure for either a mediastinoscopy, thoracotomy. 11:20:56 11:21:00 11:21:02

Q. Are you familiar with any of the costs associated with the procedures conducted by a pulmonologist, such as the performance of a bronchoscopy? 11:21:06 11:21:12 11:21:18
A. I do not have any idea of what the average cost would be for a procedure such as bronchoscopy. 11:21:20 11:21:48
Q. Doctor, would you say that some diagnostic methods for the treatment of or the assessment of a patient for lung cancer have changed since 1987? 11:22:44 11:22:46 11:22:50
A. Some diagnostic procedures have changed. I guess you would have to be more specific. 11:23:02 11:23:04
Q. Are there any better imaging techniques used to identify the presence of cancers in the lung since 1978? 11:23:18 11:23:24 11:23:24
A. The main, I guess, diagnostic tool that, such as the 11:23:36

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MRI, I think is probably what you're referring to, has been developed and more useful to us in certain settings than CT scans. 11:23:38 11:23:46 11:23:50

Although, the CT scanners have gotten to be more accurate, you know, better quality imaging. Some of the nuclear medicine things that we do are better quality. 11:23:54 11:24:02 11:24:06 11:24:06

I mean, certainly the scanners that we have in 1997 are of a better quality than in 1987. And the MRI has come into a use, but not necessarily and certainly not at the exclusion of a CT scan or a 11:24:14 11:24:24 11:24:28 11:24:32

high quality CT scanner. 11:24:34

So I think overall, all of the modalities that we have used for evaluating patients and extent of their disease have made some improvements over the last ten years. 11:24:38 11:24:44 11:24:50 11:24:50

Q. Okay. You're referring to 1987. And I assume that there would have been improvements from 1978 to 1987, as well? 11:24:56 11:25:02 11:25:02

MR. ORENSTEIN: Objection. 11:25:04

THE WITNESS: Yes. Hopefully, as with everything, the technology has continued to improve. 11:25:06 11:25:08 11:25:08

BY MR. KEMNA:

Q. Now, as to the treatment modalities that you use with lung cancer patients, would you say that those have changed since the year 1978? 11:25:14 11:25:16 11:25:20

MR. ORENSTEIN: Objection; overbroad. 11:25:24

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THE WITNESS: Are you referring to the various chemotherapy drugs that we have available to us? 11:25:28 11:25:32 11:25:32

BY MR. KEMNA:

Q. Yeah, let's focus on that for now. 11:25:36

A. Yes. Certainly in that period of time we have had many new chemotherapy drugs that have come into play. Some of them are more valuable than others in the treatment of any given disease. 11:25:42 11:25:48 11:25:52 11:25:54

Q. Doctor, are you aware that the incidence of lung cancer varies based on the geographic region of the U.S.? 11:26:24 11:26:28 11:26:28

A. I'm not familiar with the statistics. 11:26:34

Q. Do you have any sense from your education, training and experience as to whether there is a difference in the incidence of lung cancer based on geographic region of the U.S.? 11:26:44 11:26:48 11:26:52 11:26:54

MR. ORENSTEIN: Objection; beyond the scope of expert testimony. 11:26:56 11:26:56

THE WITNESS: That would not be something that I would have specific knowledge about. 11:27:00 11:27:04

BY MR. KEMNA:

Q. Doctor, are there certain drugs that are designed to be more effective against a small cell carcinoma of the lung versus a nonsmall cell carcinoma of the lung? 11:27:32 11:27:36 11:27:38 11:27:40

MR. ORENSTEIN: Objection; lack of 11:27:40

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foundation. 11:27:42

THE WITNESS: Can you read that question again? 11:27:46 11:27:46

(The requested portion read back.) 11:27:46

THE WITNESS: I do not know of any chemotherapy agents that have been developed 11:28:04 11:28:10

specifically with factors relating to small cell carcinoma of the lung in mind. 11:28:16 11:28:18

BY MR. KEMNA:

Q. Okay. Are you aware that certain chemotherapeutic agents have an indication for use in small cell carcinoma of the lung and others do not? 11:28:30 11:28:36 11:28:38

A. In our literature, there are certain drugs that have more effectiveness in small cell carcinoma of the lung than in nonsmall cell carcinoma of the lung, if that's what you're referring to. 11:28:52 11:28:56 11:29:00 11:29:02

Q. Okay. Would you give me examples of those chemotherapeutic agents you regard as more effective in the treatment of small cell carcinoma of the lung than other cell types? 11:29:06 11:29:10 11:29:14 11:29:14

A. Certainly the drug VP-16 is more effective in small cell than in nonsmall cell. A combination of Cisplatinum and VP-16, even though it is used in -- it can be used in nonsmall cell types, has a higher response rate in small cell. 11:29:26 11:29:30 11:29:36 11:29:40 11:29:46

Cytoxan, Adriamycin are also used in small cell carcinoma more effectively than nonsmall cell. 11:29:50 11:29:56

Q. Is there a particular combination of 11:30:02

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chemotherapeutic agents that you would regard as most useful to you now in treating small cell carcinoma of the lung?

A. Basically the drugs that I mentioned.
Q. Okay. Those as individual agents, I understand you are --
A. Used in combination.
Q. Okay. And I guess my question is getting to what combination of those agents might you regard now as optimal for the treatment of small cell carcinoma of the lung?
A. I'm going to object to the term "optimal," but a standard treatment regimen would be a combination of Cisplatinum and VP-16 infusion, alternating with Cytoxan, Adria, VP-16, plus or minus Vincristine.
But there are other, I mean, obviously there are other combinations that can be used in the treatment of small cell. But that is a very common protocol for or treatment combination used in small cell.
Q. Okay. Let me see if I understand correctly. I have to have a memory for these agents. The two primary agents used in combination you referred to were VP-16 and Cisplatinum?
A. Uh-hm.
Q. And then it was a question of what was the third agent that you might put into the combination for

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the treatment? 11:31:50

A. No. 11:31:52
Q. Okay. How does it work? I mean, are you using only the two agents in combination and then switching between the two with another agent, or how does that work? 11:31:56 11:31:58 11:32:02 11:32:02
A. A course, for instance, that would not be uncommon would be for the patient to have a four-day infusion of Cisplatinum and VP-16 that would be continuous, followed the next month by outpatient therapy with Cytoxan, Adriamycin, VP-16, perhaps Vincristine, followed the next month by the infusion chemotherapy aforementioned, followed by outpatient chemotherapy as mentioned. 11:32:08 11:32:10 11:32:16 11:32:20 11:32:28 11:32:32 11:32:36 11:32:40
Depending upon the response rate at that point in time, the patient may continue on outpatient therapy. They may have radiation therapy added to their treatment. They may be switched to alternative drugs, depending upon the response rate at that point in time. 11:32:42 11:32:48 11:32:52 11:32:54 11:32:58 11:33:00
Q. Is the choice of chemotherapeutic agents, the particular combination used in one course and then changes made in following courses of chemotherapy in an individual patient, somewhat of a, this is sort of a casual reference, trial and error process? 11:33:26 11:33:30 11:33:32 11:33:40 11:33:42
MR. ORENSTEIN: Objection; ambiguous. 11:33:46

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THE WITNESS: I would have to have you explain what you mean by trial and error. The drugs are not picked out of the air. 11:33:48 11:33:52 11:33:52

BY MR. KEMNA:

Q. No, I understand that, Doctor, and you've already indicated which ones that you believe are most often indicated or most effective in dealing with small cell carcinoma of the lung. 11:33:56 11:33:58 11:34:02 11:34:04

Among those agents, in trying to identify what might be the best course to be used against the disease in an individual patient is somewhat arrived at in an trial and error kind of approach? 11:34:08 11:34:14 11:34:18 11:34:22

MR. ORENSTEIN: Objection; ambiguous. 11:34:24

THE WITNESS: When a group of drugs is picked for a treatment of cancer, it is based on research as to a group of drugs that is effective in that disease. 11:34:28 11:34:30 11:34:36 11:34:42

For a given person, we do not have sensitivities of the tumor to the drugs, so we cannot tell for a given patient whether that set of drugs will be effective in treatment of their cancer. 11:34:44 11:34:50 11:34:56 11:35:00 11:35:02

And that is why we need to follow them carefully to make sure we're getting the response that we would require to continue with that course 11:35:04 11:35:08 11:35:12

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of therapy for that patient. 11:35:14

BY MR. KEMNA:

Q. Okay. In administering chemotherapy to a patient, over the course of time, initial course of chemotherapy, some changes made for the second course, again maybe changes made for the third course, and an observation of the response of the chemotherapy along the way, do you get clues as to what the exact cell type of the cancer may be, if it's not all that well-defined at the outset? 11:35:26 11:35:30 11:35:36 11:35:40 11:35:42 11:35:46 11:35:56 11:36:00

A. I do not think that you can use the response of the tumor to a chemotherapy drug to retrospectively say this cancer -- that the cancer diagnosis or the tissue diagnosis has changed. 11:36:08 11:36:16 11:36:20 11:36:22

Q. Okay. If you have an indeterminate tissue diagnosis at the outset, let's say you have a finding by the pathologist at biopsy that the tissue is definitely malignant, but identifying a particular cell type is just not capable of being determined, and then you set about the treatment process with chemotherapy, would you get any clues based upon the response to the chemotherapeutic agents? 11:36:26 11:36:32 11:36:36 11:36:42 11:36:48 11:36:54 11:36:58 11:37:02

A. I think the only clue you would get is what agents may be effective in treatment of this patient. 11:37:08 11:37:10

Q. If the standard combination chemotherapy that is 11:37:20

recognized for use in small cell results in no response in somehow reducing the size of the tumor or stemming the growth of the tumor, would you 11:37:24 11:37:32 11:37:34

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suspect that in that particular case it may not be a small cell carcinoma of the lung? 11:37:38 11:37:40

MR. ORENSTEIN: Objection; calls for speculation. 11:37:42 11:37:42

THE WITNESS: There is enough variability in response rates in any study that you could not draw that conclusion from that information. 11:37:46 11:37:50 11:37:52

BY MR. KEMNA:

Q. Doctor, are you aware of the statistical information reported by the Office of the Surgeon General that risk -- excuse me, the risk associated with cigarette smoking regarding the incidence of lung cancer declines over time dating from the day of quitting for the smoker? 11:39:12 11:39:20 11:39:26 11:39:30 11:39:38 11:39:42

MR. ORENSTEIN: Objection; assumes facts not in evidence. 11:39:44 11:39:44

THE WITNESS: I would have to review that report to comment on that. 11:39:48 11:39:56

BY MR. KEMNA:

Q. Are you aware that the risk of lung cancer associated with cigarette smoking does decline over time from the date of stopping smoking? 11:40:10 11:40:16 11:40:18

A. I do not know the statistics on that. I think that there have been some articles that have looked at that and have shown some improvement over the years, but I do not know how much improvement and when that improvement, if it truly exists statistically, 11:40:28 11:40:32 11:40:38 11:40:42 11:40:48

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starts. 11:40:50
Q. Okay. And by using the word "improvement," you're 11:40:52
referring to reduction in the risk; is that 11:40:54
correct?
A. Right. 11:40:56
Q. In making -- as you have indicated in your prior 11:41:04
testimony, identifying cigarette smoking as a 11:41:08
contributing factor to lung cancer, does it make any 11:41:12
difference to you in any individual the fact of 11:41:20
quitting smoking? 11:41:22
MR. ORENSTEIN: Objection; vague. 11:41:26
THE WITNESS: I guess how do you mean 11:41:32
that? As far as their -- 11:41:36
BY MR. KEMNA:
Q. If you were looking at an individual patient and you 11:41:44
were to try to advise that patient regarding the 11:41:46
degree of risk that may be associated with smoking 11:41:52
behavior and it was made clear to you by this 11:41:58
patient that that patient had stopped smoking ten 11:42:00
years ago, would that make any difference to you in 11:42:06

terms of determining whether that patient was at 11:42:08
increased risk for the development of lung cancer? 11:42:12
MR. ORENSTEIN: Objection; lack of 11:42:14
foundation, assumes facts not in evidence. 11:42:16
THE WITNESS: Again, that information 11:42:18
would not be relevant for seeing a patient diagnosed 11:42:24
with lung cancer, whether they had an increased or 11:42:28
decreased risk of developing that cancer, but 11:42:32

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developed it and showed up at my door. Whatever happened to that particular patient was 100 percent for that patient. So I'm not sure exactly what your question is. 11:42:34 11:42:36 11:42:40 11:42:44

BY MR. KEMNA:

Q. Perhaps my question, you might have assumed something in my question that wasn't intended. But you treat patients for diseases other than lung cancer, don't you? 11:42:46 11:42:48 11:42:52 11:42:52

A. That's correct. 11:42:54

Q. Okay. And the patients that you treat for conditions other than lung cancer would include cancers at other sites in the body; is that correct? 11:43:00 11:43:02 11:43:08 11:43:08

A. That is correct. 11:43:08

Q. Now, if a patient comes to you and they're currently a cigarette smoker, they don't have the diagnosis of lung cancer, do you give them any advice to quit smoking? 11:43:16 11:43:20 11:43:22 11:43:24

A. Yes. 11:43:24

Q. What do you tell them? 11:43:24

A. I tell them that their risk of other cancers and just generally their overall health will be improved if they quit smoking, and I advise them the same on a low-fat diet. 11:43:34 11:43:38 11:43:44 11:43:44

Q. And so the basis for you giving that advice to the patient is to tell them that they have something to 11:43:50 11:43:54

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benefit from stopping smoking towards some potential health consequence that's been associated with cigarette smoking; is that accurate? 11:43:58 11:44:00 11:44:02

A. That is accurate. 11:44:04

Q. If someone had stopped smoking 15 years prior to coming to your office but they present with lung cancer, would you say that their cigarette smoking history was a significant contributing factor to their lung cancer? 11:44:16 11:44:18 11:44:22 11:44:26 11:44:26

MR. ORENSTEIN: Objection; lack of foundation. 11:44:28 11:44:28

THE WITNESS: Again, that would be a speculation on the basis of just a case report, and I would have to look at the case. 11:44:32 11:44:34 11:44:36

BY MR. KEMNA:

Q. In that situation where you have a history of cigarette smoking ending 15 years prior to the date of diagnosis of the lung cancer, would you make any conclusion regarding the role of cigarette smoking in that individual's lung cancer? 11:44:46 11:44:50 11:45:00 11:45:02 11:45:04

MR. ORENSTEIN: Objection; lack of foundation, calls for speculation. 11:45:06 11:45:08

THE WITNESS: Again, you're talking about an individual patient and whatever happens to that patient is 100 percent. How that correlates to statistics in the population is not very relevant to that patient, and I would not speculate for that patient. 11:45:12 11:45:14 11:45:18 11:45:24 11:45:26 11:45:26

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BY MR. KEMNA:

Q. Okay. You just don't make those kinds of assessments in the course of your practice? 11:45:36 11:45:38

A. That's right. 11:45:40

Q. If you were presented with information from a particular medical file of a Medicaid patient that has been identified in the context of this case and you were asked to review that information and you identified that the person had stopped smoking 15 years prior to a lung cancer diagnosis, would you be in a position to make any statement regarding a potential role of cigarette smoking in that person's 11:45:50 11:45:54 11:46:02 11:46:04 11:46:06 11:46:10 11:46:12 11:46:16

lung cancer? 11:46:16

MR. ORENSTEIN: Objection; lack of foundation, calls for speculation, assumes facts not in evidence. 11:46:18 11:46:20 11:46:22

THE WITNESS: Again, you would have to look at population studies and percentage of decrease in lung cancer with time, and how that relates to that patient is beyond my scope. 11:46:24 11:46:28 11:46:34 11:46:40

BY MR. KEMNA:

Q. It's beyond your expertise to make a statement on that; is that correct? 11:46:44 11:46:44

A. For that particular patient, yes, definitely. 11:46:46

Q. Doctor, you signed your expert report that's dated June 2 on the cover page, but actually you have a May 30, 1997 date on the second page of Exhibit 11:48:18 11:48:22 11:48:30

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2503; is that correct? 11:48:38

A. Yep. 11:48:42

Q. Any changes that you would like to make to your expert report since we've had some months in the intervening time between May 30 and today? 11:48:48 11:48:52 11:48:56

A. I do not wish to make any changes in my written report, no. 11:49:04 11:49:06

Q. All right. Would you anticipate doing any further work in preparation for testifying at the trial of this matter? 11:49:10 11:49:16 11:49:16

MR. ORENSTEIN: Objection; calls for speculation. 11:49:18 11:49:20

THE WITNESS: Since what -- I'm sorry, the -- since the time that I wrote this -- 11:49:30 11:49:38

BY MR. KEMNA:

Q. Just today, as you sit here today, in your present state of understanding about the scope of your expert opinions and what is reflected in your written report, would you anticipate doing any further work to prepare substantive opinions that you may make at the trial of this matter, you may give at the trial of this matter? 11:49:42 11:49:48 11:49:52 11:49:56 11:50:04 11:50:08 11:50:10

MR. ORENSTEIN: Objection. 11:50:10

THE WITNESS: I guess I'm not sure what types of things you're talking about. 11:50:12 11:50:14

BY MR. KEMNA:

Q. Do you anticipate any other aspect of offering testimony in this case other than what you've 11:50:18 11:50:20

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already indicated by your expert report and by your testimony at this deposition? 11:50:22 11:50:24

A. I think basically my testimony will be and the scope of what's in this report, obviously we have -- there are other experts whose information since I have written this report I've had the opportunity to look at. 11:50:30 11:50:34 11:50:42 11:50:46 11:50:50

But that's already, I mean, there are other experts whose reports will be available to me to look at. 11:50:54 11:51:00 11:51:00

Q. And would the other expert reports that you have the opportunity to look at change in any respect the scope of your opinions or the nature of your opinions? 11:51:14 11:51:16 11:51:20 11:51:20

A. The scope of my opinions have to deal with the treatment, evaluation, follow-up of the oncology patients and the costs thereof. But I'm not sure exactly how to answer your question, I guess. 11:51:28 11:51:34 11:51:44 11:51:48

Q. Now, Doctor, we touched on this the other day, it relates to the board exam that you took for the subspecialty of oncology. 11:51:56 11:52:00 11:52:04

After sitting for the boards on that occasion that you testified about, did you ever go back and attempt to take the boards again? 11:52:08 11:52:14 11:52:16

A. No. 11:52:18

MR. KEMNA: Let's take a break. 11:52:24

THE VIDEOGRAPHER: The time is now 11:52 11:52:28

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and we are temporarily going off the video record. 11:52:32

(Off the record.) 11:52:34

THE VIDEOGRAPHER: We're back on the video 12:00:30

record. The time is now 12:00 p.m. 12:00:34

BY MR. KEMNA:

Q. Doctor, of the patients that you are currently 12:00:44

following up for lung cancer treatment, how many of 12:00:48

those are in a nursing home setting for their living 12:00:56

environment? 12:00:56

MR. ORENSTEIN: Objection; lack of 12:00:58

foundation. 12:00:58

THE WITNESS: I would not have that number 12:01:00

available without much more preparation and 12:01:06

evaluation through the records. 12:01:08

BY MR. KEMNA:

Q. In your present recollection of the patients you are 12:01:12

treating and following up for lung cancer, can you 12:01:20

say whether any of them are in a nursing home 12:01:22

setting for their living environment? 12:01:24

A. Of the ones that I'm currently treating, I cannot 12:01:32

think of an individual that is living in a nursing 12:01:36

home. 12:01:36

Q. Doctor, would you like to see smoking banned in the 12:01:52

United States? 12:01:52

MR. ORENSTEIN: Objection; beyond the 12:01:54

scope of her expert testimony. 12:01:56

THE WITNESS: I think that is beyond what 12:02:00

I am here to testify on. 12:02:02

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BY MR. KEMNA:

Q. Well, I recognize it's not within the specified 12:02:06

opinions in your expert report, but it does get to 12:02:08
relevant aspects of an expert testifying in a 12:02:12
matter. So I'll ask you to answer the question. 12:02:14
MR. ORENSTEIN: Object to your legal 12:02:16
conclusion. 12:02:18
THE WITNESS: I can say as an individual 12:02:22
and a nonsmoker that I would like to have a 12:02:30
smoke-free environment, yes. 12:02:32

BY MR. KEMNA:

Q. Okay. By saying that, are you saying that 12:02:36
individuals should not be able to smoke in the 12:02:42
United States if it was constructed the way you 12:02:48
would like to have it, not having smoking around 12:02:50
you? 12:02:50
MR. ORENSTEIN: Objection; ambiguous, 12:02:52
compound question, mischaracterizes her testimony. 12:02:56
THE WITNESS: And I do not feel I can 12:02:58
answer that question in the scope of this 12:03:02
deposition. 12:03:02

BY MR. KEMNA:

Q. You have no view on that? 12:03:06

A. I have no view I would wish to express at this point 12:03:16
in time. 12:03:16

Q. You have views, but you just won't express those 12:03:18
views, is that -- 12:03:20

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A. I have not compiled those views and thought about them, so I do not wish to answer that. It's beyond the scope of what I'm here to talk about and prepared to talk about. I'm just not prepared to talk about that. 12:03:24 12:03:28 12:03:34 12:03:36 12:03:36

MR. KEMNA: That's all the questions I have. 12:03:38 12:03:38

EXAMINATION

BY MR. ORENSTEIN: 12:03:42

Q. Doctor, I have just a couple of questions. Can we agree, as you agreed with defense counsel, that you need to give audible answers to my questions? 12:03:50 12:03:54 12:03:56

A. Yes. 12:03:56

Q. Doctor, if we could return to Exhibit 2503 for a minute, would you look at the last paragraph on the last page. 12:04:10 12:04:24 12:04:24

A. Yes. 12:04:28

Q. Would you please just read that paragraph into the record. 12:04:32

A. "As the above narrative shows, lung cancer patients need an enormous amount of health care, and much of it is very costly. For a patient seen in my office, the annual cost for office visits, labs and chemotherapy can range from a few thousand to greater than 20,000 a year. Hospital and nursing 12:04:38 12:04:40 12:04:44 12:04:48 12:04:50 12:04:54

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home costs and other costs can add dollars to these bills considerably. 12:04:58 12:05:00

"In my clinical experience, the services are medically necessary. Further, the fees paid by State of Minnesota programs are below those reasonable for the market. And the fees paid by Blue Cross and Blue Shield of Minnesota are reasonable and consistent with the market." 12:05:04 12:05:08 12:05:10 12:05:12 12:05:14 12:05:16

Q. Doctor, at the time that you wrote that paragraph for your expert report, did you hold those views to a reasonable degree of medical certainty? 12:05:24 12:05:26 12:05:28

A. I did. 12:05:30

Q. And as we sit here today, do you still hold those views to a reasonable degree of medical certainty? 12:05:34 12:05:36

A. I do. 12:05:36

Q. Now, Doctor, in earlier questioning, if my recollection is correct, you began an answer regarding the costs that you discussed in that paragraph? 12:05:44 12:05:50 12:05:56 12:05:56

A. Yes. 12:05:58

Q. The first part of that answer used the word "vague." And, Doctor, my question to you now is: Did you intend for your answer, as you went on to complete it, to mean that the cost ranges that you described in this report were vague? 12:06:02 12:06:06 12:06:08 12:06:12 12:06:14

A. No. 12:06:16

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MR. KEMNA: Objection. 12:06:18

THE WITNESS: In fact, I corrected that 12:06:20
immediately with the term, I believe, "broad." What 12:06:26
this is is a broad spectrum that we are looking at 12:06:28
from people who require minimal care to people who 12:06:34
require fairly extensive and aggressive care. 12:06:42

The dollar amount is quite a broad 12:06:44
spectrum. And I corrected that, I believe. As soon 12:06:48
as I said the word "vague," I interposed, I think, 12:06:52
the term "broad." 12:06:54

BY MR. ORENSTEIN:

Q. And that's how you mean it? 12:06:58

A. And that's how I mean it. 12:07:00

Q. And you did not mean in any way -- well, Doctor, did 12:07:18
you mean by any of your testimony to in any way 12:07:22
depart from your statement that you just read that 12:07:26
the fees paid by the State of Minnesota programs are 12:07:32
below those reasonable for the market? 12:07:34

A. No, I did not mean to depart from that. 12:07:42

Q. And that's the testimony that you intend to give? 12:07:44

A. Yes. 12:07:46

MR. KEMNA: Objection. The testimony is 12:07:48
on the record, Howard. Going back and trying to 12:07:50
correct it globally with that type of a question is 12:07:52

inappropriate and certainly is beyond the scope of 12:07:58
what appropriate questioning should be. 12:08:00

MR. ORENSTEIN: Well, please try to limit 12:08:02
your objections to a narrow basis, as I did. 12:08:06

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BY MR. ORENSTEIN:

Q. Doctor, do you remember the discussion with defense counsel on Wednesday regarding your sitting for the oncology boards? 12:08:14 12:08:20 12:08:20

A. Yes. 12:08:20

Q. Do you consider, as you sit here today, or even as you sat there on Wednesday when we first started this deposition, that you failed those oncology boards? 12:08:32 12:08:36 12:08:38 12:08:40

A. I failed to complete them. 12:08:40

Q. Do you consider that you failed them? 12:08:44

A. I failed to complete them, thus I could not pass them. But I do not feel as though I failed them in the sense of completing them and failing them in that manner. 12:08:48 12:08:54 12:08:58 12:09:04

The boards when they are given, you are notified whether you have gotten your board certification, and I did not get my board certification because I did not complete the test so could not have possibly gotten it without completing more of the questions. 12:09:08 12:09:12 12:09:16 12:09:20 12:09:26 12:09:26

Q. And, Doctor, why was it that you were not able to complete the exam on the day that you sat for it? 12:09:34 12:09:36

A. I was having -- I was pregnant at the time and began having contractions during the exam, had to excuse myself a number of times from the exam, and finally just needed to leave the exam. 12:09:40 12:09:48 12:09:52 12:09:56

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Q. So you did not leave the exam the first time you started having these contractions? 12:10:00 12:10:02

A. No. 12:10:04

Q. You tried to complete it? 12:10:04

A. I tried to stay into the afternoon to try and get through the exams. 12:10:10 12:10:12

Q. But did you reach a point where you thought it was not wise to continue to try to complete the exam? 12:10:16 12:10:18

A. Yes. 12:10:18

Q. And was that for health reasons? 12:10:22

A. It was -- yes, definitely. I was basically unable to complete them because of the pain that I was having and the need to be in a supine position to try and decrease the number of contractions I was having. 12:10:32 12:10:36 12:10:44 12:10:46 12:10:46

MR. ORENSTEIN: Thank you, I don't have any further questions. 12:10:50 12:10:50

THE WITNESS: Thank you. 12:10:50

CONTINUING EXAMINATION

BY MR. KEMNA: 12:10:52

Q. I have just a couple more, Doctor. After having sat for the board exam on the initial occasion, you were certainly qualified to go back and sit for the board exam on a follow-up occasion, were you not? 12:10:56 12:11:02 12:11:06 12:11:10

A. Yes. 12:11:10

Q. And was there anything that prevented you from sitting for the oncology boards once again to enable 12:11:16 12:11:24

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yourself to complete those boards towards certification in your specialty? 12:11:26 12:11:28

A. I could still do it as of the next time they're offered if I chose to do so. 12:11:32 12:11:36

Q. Doctor, how is it that you made an assessment of what the current market is for costs associated and reimbursed for the treatment of lung cancer, as you described it in the last paragraph of your report? 12:11:42 12:11:52 12:11:58 12:12:00

MR. ORENSTEIN: Counsel, are you going to go back into areas that you've already covered? 12:12:04 12:12:06

MR. KEMNA: No, these are areas that you covered in your examination, so this is strictly limited to the areas that you addressed. 12:12:08 12:12:12 12:12:14

MR. ORENSTEIN: Okay. 12:12:14

THE WITNESS: Again, going back to the business office indicating that Blue Cross/Blue 12:12:20 12:12:28

Shield pays -- reimburses us at the rate consistent with the other insurance companies that we deal with, that they are within a range, but within the same ballpark. 12:12:34 12:12:38 12:12:42 12:12:44

BY MR. KEMNA:

Q. So it's a ballpark estimate of the market? 12:12:48

A. We have -- 12:12:52

MR. ORENSTEIN: Objection. 12:12:52

BY MR. KEMNA:

Q. Go ahead.

A. The reimbursement of one insurance company to 12:13:00

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another is a comparison by some conversion factor that they use. 12:13:10 12:13:12

I do not understand the conversion factors, and you'd have to ask the insurance company how they, you know, what the significance of their conversion factor is, but conversion factor for Blue Cross and Blue Shield of Minnesota is similar to other insurance programs that we deal with. 12:13:14 12:13:18 12:13:20 12:13:26 12:13:26 12:13:32

And whatever the conversion factor is, I'm not able to explain to you or what that equates dollar amount wise. 12:13:36 12:13:46 12:13:48

Q. So your testimony regarding a comparison of fees paid by the State of Minnesota to the market, as you have it stated here, is sort of a general 12:14:06 12:14:12 12:14:24

understanding of the relative amounts reimbursed from Medicaid versus what gets reimbursed from other programs? 12:14:28 12:14:34 12:14:34

MR. ORENSTEIN: Objection; mischaracterizes the testimony. 12:14:38 12:14:38

THE WITNESS: I guess -- we're not talking about specific things that are reimbursed. 12:14:42 12:14:46

BY MR. KEMNA:

Q. Right, you're talking about costs. 12:14:52

A. We're talking about how the conversion factors relate to what we get back. And how that equates to an individual charge in reimbursement for that charge, I have no idea. 12:14:56 12:15:00 12:15:06 12:15:06

Q. So overall you have no idea how the reimbursement 12:15:10

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for costs from the Medicaid program compares to the market? 12:15:18

A. Well, there's a very -- 12:15:20

MR. ORENSTEIN: Objection; mischaracterizes her testimony. 12:15:20

THE WITNESS: There's a very specific relationship with this conversion factor, but I am not -- I cannot tell you what that conversion factor is or what the meaning of that conversion factor -- you'd have to talk to the people that deal with that. 12:15:22

MR. KEMNA: I don't have any other questions. 12:15:44

MR. ORENSTEIN: We'd like to read and sign. 12:15:46

THE VIDEOGRAPHER: Thank you. The time is now 12:15 and this concludes Dr. Bowers' testimony. 12:15:48

(Off the record.) 12:15:50

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STATE OF MINNESOTA)
)
COUNTY OF HENNEPIN)

BE IT KNOWN THAT I, JENNIFER S. SATI, took the DEPOSITION OF BARBARA J. BOWERS, M.D. VOLUME II;

THAT, I was then and there a Notary Public in and for the County of Hennepin, State of Minnesota;

THAT, I exercised the power of that office in taking said deposition;

THAT, by virtue thereof I was then and there authorized to administer an oath;

THAT, said witness, before testifying, was duly sworn to testify to the truth, the whole truth, and nothing but the truth, relative to this action;

THAT, said witness reserved the right to read and sign the deposition;

THAT said deposition is a true record of the testimony given by the witness;

THAT, I am neither attorney nor counsel for, nor related to or employed by any of the parties to this action in which this deposition is taken and, further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, or financially interested in this action.

DATED THIS 12th DAY OF August, 1997.

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JENNIFER S. SATI, RPR, CRR
Notary Public, Henn. County, Minn.
My Comm. Expires January 31, 2000

ERRATA SHEET

RE: Minnesota Tobacco Litigation

Barbara J. Bowers, M.D., Volume II

I, BARBARA J. BOWERS, M.D., do hereby certify that I have read the foregoing transcript of the proceedings taken on July 25, 1997, and believe the same to be true and correct, except as follows:

PAGE	LINE	DESIRED CHANGE

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